

Senate File 389 - Introduced

SENATE FILE _____
BY COMMITTEE ON HUMAN
RESOURCES

(SUCCESSOR TO SF 48)

Passed Senate, Date _____ Passed House, Date _____
Vote: Ayes _____ Nays _____ Vote: Ayes _____ Nays _____
Approved _____

A BILL FOR

1 An Act relating to health care, health care providers, and health
2 care coverage, providing penalties, and providing retroactive
3 and other effective dates.
4 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:
5 TLSB 1747SV 83
6 pf/rj/14

PAG LIN

1 1 DIVISION I
1 2 IOWA CHOICE INSURANCE EXCHANGE
1 3 Section 1. NEW SECTION. 514M.1 SHORT TITLE.
1 4 This chapter shall be known and may be cited as the "Iowa
1 5 Choice Insurance Exchange Act".
1 6 Sec. 2. NEW SECTION. 514M.2 PURPOSE.
1 7 It is the purpose of this chapter to:
1 8 1. Ensure that all children in the state have affordable,
1 9 quality health care coverage with the following priorities:
1 10 a. Provide funding to cover all children who are eligible
1 11 for Medicaid and hawk=i by December 31, 2010.
1 12 b. As funding becomes available, provide subsidized
1 13 coverage which meets certain standards of quality and
1 14 affordability to the remaining uninsured children less than
1 15 nineteen years of age under a sliding scale based on family
1 16 income.
1 17 c. Require all parents of children less than nineteen
1 18 years of age to indicate on their Iowa tax returns whether
1 19 their children have health care coverage.
1 20 d. Require that all parents of children less than nineteen
1 21 years of age with a family income that is less than three
1 22 hundred percent of the federal poverty level must provide
1 23 proof of qualified health care coverage for their children
1 24 which meets certain standards of quality and affordability.
1 25 e. Move towards a future requirement that all parents of
1 26 children must provide proof of qualified health care coverage
1 27 for their children which meets certain standards of quality
1 28 and affordability.
1 29 2. Ensure that all Iowans have qualified health care
1 30 coverage which meets certain standards of quality and
1 31 affordability with the following priorities:
1 32 a. Continue to expand options for individuals who are
1 33 dually eligible for Medicare and Medicaid, typically the
1 34 chronically disabled, by utilizing evidence-based medical
1 35 treatments.
2 1 b. Ensure that all health and long-term care workers have
2 2 qualified health care coverage which meets certain standards
2 3 of quality and affordability.
2 4 c. Maximize eligibility of low-income adults nineteen
2 5 years of age and older for public health care coverage.
2 6 d. As funding becomes available, provide subsidized
2 7 coverage which meets certain standards of quality and
2 8 affordability to the remaining low-income adults.
2 9 e. Move towards a future requirement that all Iowans must
2 10 provide proof of qualified health care coverage which meets
2 11 certain standards of quality and affordability.
2 12 3. Decrease health care costs and health care coverage
2 13 costs by:
2 14 a. Instituting insurance reforms that assure the

2 15 availability of private insurance coverage for all Iowans by
2 16 addressing issues involving guaranteed availability and issue
2 17 of insurance to applicants; preexisting condition exclusions;
2 18 portability; and allowable or required pooling and rating
2 19 classifications.
2 20 b. Requiring every child who has public health care
2 21 coverage or is insured by a plan created by the Iowa health
2 22 care coverage exchange to have a medical home as defined in
2 23 section 135.157.
2 24 c. Establishing a statewide telehealth system.
2 25 d. Implementing cost containment strategies such as
2 26 disease management programs, advance medical directives or end
2 27 of life planning initiatives, transparency in health care cost
2 28 and quality information, and an expanded certificate of need
2 29 process.
2 30 4. Develop a program to offer health care coverage under
2 31 the state health or medical group insurance plan to nonstate
2 32 public employees, including employees of counties, cities,
2 33 schools, and community colleges, and employees of nonprofit
2 34 employers and small employers and to pool such employees with
2 35 the state plan.

3 1 Sec. 3. NEW SECTION. 514M.3 DEFINITIONS.

3 2 As used in this chapter, unless the context otherwise
3 3 requires:

3 4 1. "Board" means the board of directors of the Iowa choice
3 5 insurance exchange.

3 6 2. "Carrier" means an insurer providing accident and
3 7 sickness insurance under chapter 509, 514, or 514A and
3 8 includes a health maintenance organization established under
3 9 chapter 514B if payments received by the health maintenance
3 10 organization are considered premiums pursuant to section
3 11 514B.31 and are taxed under chapter 432. "Carrier" also
3 12 includes a corporation which becomes a mutual insurer pursuant
3 13 to section 514.23 and any other person as defined in section
3 14 4.1, subsection 20, who is or may become liable for the tax
3 15 imposed by chapter 432.

3 16 3. "Commissioner" means the commissioner of insurance.

3 17 4. "Creditable coverage" means health benefits or coverage
3 18 provided to an individual under any of the following:

3 19 a. A group health plan.

3 20 b. Health insurance coverage.

3 21 c. Part A or part B Medicare pursuant to Title XVIII of
3 22 the federal Social Security Act.

3 23 d. Medicaid pursuant to Title XIX of the federal Social
3 24 Security Act, other than coverage consisting solely of
3 25 benefits under section 1928 of that Act.

3 26 e. 10 U.S.C. ch. 55.

3 27 f. A health or medical care program provided through the
3 28 Indian health service or a tribal organization.

3 29 g. A state health benefits risk pool.

3 30 h. A health plan offered under 5 U.S.C. ch. 89.

3 31 i. A public health plan as defined under federal
3 32 regulations.

3 33 j. A health benefit plan under section 5(e) of the federal
3 34 Peace Corps Act, 22 U.S.C. } 2504(e).

3 35 k. An organized delivery system licensed by the director
4 1 of public health.

4 2 1. The hawk=i program authorized by chapter 514I.

4 3 5. "Director" means the director of revenue.

4 4 6. "Exchange" means the Iowa choice insurance exchange.

4 5 7. "Executive director" means the executive director of
4 6 the Iowa choice insurance exchange.

4 7 8. "Federal poverty level" means the most recently revised
4 8 income guidelines published by the United States department of
4 9 health and human services.

4 10 9. a. "Group health plan" means an employee welfare
4 11 benefit plan as defined in section 3(1) of the federal
4 12 Employee Retirement Income Security Act of 1974, to the extent
4 13 that the plan provides medical care including items and
4 14 services paid for as medical care to employees or their
4 15 dependents as defined under the terms of the plan directly or
4 16 through insurance, reimbursement, or otherwise.

4 17 b. For purposes of this subsection, "medical care" means
4 18 amounts paid for any of the following:

4 19 (1) The diagnosis, cure, mitigation, treatment, or
4 20 prevention of disease, or amounts paid for the purpose of
4 21 affecting a structure or function of the body.

4 22 (2) Transportation primarily for and essential to medical
4 23 care referred to in subparagraph (1).

4 24 (3) Insurance covering medical care referred to in
4 25 subparagraph (1) or (2).

4 26 c. For purposes of this subsection, the following apply:
4 27 (1) A plan, fund, or program established or maintained by
4 28 a partnership which, but for this subsection, would not be an
4 29 employee welfare benefit plan, shall be treated as an employee
4 30 welfare benefit plan which is a group health plan to the
4 31 extent that the plan, fund, or program provides medical care,
4 32 including items and services paid for as medical care for
4 33 present or former partners in the partnership or to the
4 34 dependents of such partners, as defined under the terms of the
4 35 plan, fund, or program, either directly or through insurance,
5 1 reimbursement, or otherwise.
5 2 (2) With respect to a group health plan, the term
5 3 "employer" includes a partnership with respect to a partner.
5 4 (3) With respect to a group health plan, the term
5 5 "participant" includes the following:
5 6 (a) With respect to a group health plan maintained by a
5 7 partnership, an individual who is a partner in the
5 8 partnership.
5 9 (b) With respect to a group health plan maintained by a
5 10 self-employed individual under which one or more of the
5 11 self-employed individual's employees are participants, the
5 12 self-employed individual, if that individual is, or may
5 13 become, eligible to receive benefits under the plan or the
5 14 individual's dependents may be eligible to receive benefits
5 15 under the plan.
5 16 10. "Health care services" means services, the coverage of
5 17 which is authorized under chapter 509, 514, 514A, or 514B as
5 18 limited by benefit plans established by the exchange's board
5 19 of directors, with the approval of the commissioner and
5 20 includes services for the purposes of preventing, alleviating,
5 21 curing, or healing human illness, injury, or physical
5 22 disability.
5 23 11. "Health insurance" means accident and sickness
5 24 insurance authorized by chapter 509, 514, or 514A.
5 25 12. a. "Health insurance coverage" means health insurance
5 26 coverage offered to individuals, including group conversion
5 27 coverage.
5 28 b. "Health insurance coverage" does not include any of the
5 29 following:
5 30 (1) Coverage for accident-only or disability income
5 31 insurance.
5 32 (2) Coverage issued as a supplement to liability
5 33 insurance.
5 34 (3) Liability insurance, including general liability
5 35 insurance and automobile liability insurance.
6 1 (4) Workers' compensation or similar insurance.
6 2 (5) Automobile medical-payment insurance.
6 3 (6) Credit-only insurance.
6 4 (7) Coverage for on-site medical clinic care.
6 5 (8) Other similar insurance coverage, specified in federal
6 6 regulations, under which benefits for medical care are
6 7 secondary or incidental to other insurance coverage or
6 8 benefits.
6 9 c. "Health insurance coverage" does not include benefits
6 10 provided under a separate policy as follows:
6 11 (1) Limited-scope dental or vision benefits.
6 12 (2) Benefits for long-term care, nursing home care, home
6 13 health care, or community-based care.
6 14 (3) Any other similar limited benefits as provided by rule
6 15 of the commissioner.
6 16 d. "Health insurance coverage" does not include benefits
6 17 offered as independent noncoordinated benefits as follows:
6 18 (1) Coverage only for a specified disease or illness.
6 19 (2) A hospital indemnity or other fixed indemnity
6 20 insurance.
6 21 e. "Health insurance coverage" does not include Medicare
6 22 supplemental health insurance as defined under section
6 23 1882(g)(1) of the federal Social Security Act, coverage
6 24 supplemental to the coverage provided under 10 U.S.C. ch. 55
6 25 and similar supplemental coverage provided to coverage under
6 26 group health insurance coverage.
6 27 13. "Insured" means an individual who is provided
6 28 qualified health care coverage under a policy, which policy
6 29 may include dependents and other covered persons.
6 30 14. "Medical assistance program" means the federal-state
6 31 assistance program established under Title XIX of the federal
6 32 Social Security Act and chapter 249A.
6 33 15. "Medicare" means the federal government health
6 34 insurance program established under Title XVIII of the federal
6 35 Social Security Act.
7 1 16. "Organized delivery system" means an organized

7 2 delivery system as licensed by the director of public health.
7 3 17. "Policy" means a contract, policy, or plan of health
7 4 insurance.

7 5 18. "Policy year" means a consecutive twelve-month period
7 6 during which a policy provides or obligates the carrier to
7 7 provide health insurance.

7 8 19. "Qualified health care coverage" means creditable
7 9 coverage which meets minimum standards of quality and
7 10 affordability as determined by the board by rule.

7 11 20. "Resident" means a person who is a resident of this
7 12 state for state income tax purposes.

7 13 Sec. 4. NEW SECTION. 514M.4 IOWA CHOICE INSURANCE
7 14 EXCHANGE CREATED == BOARD OF DIRECTORS.

7 15 1. The Iowa choice insurance exchange is created as a
7 16 nonprofit corporation under the purview of the insurance
7 17 division of the department of commerce.

7 18 a. All carriers and all organized delivery systems
7 19 licensed by the director of public health providing health
7 20 insurance or health care services in Iowa, whether on an
7 21 individual or group basis, and all other insurers designated
7 22 by the exchange's board of directors and approved by the
7 23 commissioner shall be members of the exchange.

7 24 b. The exchange shall operate under a plan of operation
7 25 established and approved under section 514M.5 and shall
7 26 exercise its powers through a board of directors established
7 27 under this section.

7 28 2. The board of directors of the exchange shall consist of
7 29 the following members:

7 30 a. Persons who are voting members of the board appointed
7 31 by the governor and subject to confirmation by the senate:

7 32 (1) A practicing physician licensed to practice medicine
7 33 and surgery or osteopathic medicine and surgery.

7 34 (2) A practicing nurse licensed as a registered nurse or a
7 35 licensed practical nurse or vocational nurse.

8 1 (3) A representative of the federation of Iowa insurers.

8 2 (4) A health economist who resides in Iowa.

8 3 (5) A health benefit manager.

8 4 (6) A consumer who is a representative of a children's
8 5 advocacy organization.

8 6 (7) A consumer who is a representative of the state's
8 7 adult uninsured population.

8 8 (8) A consumer who is a member of a racial or ethnic
8 9 minority group.

8 10 (9) A representative of organized labor.

8 11 (10) A representative of an organization of small
8 12 businesses.

8 13 (11) A representative of the alliance of nonprofit
8 14 agencies.

8 15 b. Persons who are ex officio, nonvoting members of the
8 16 board:

8 17 (1) The commissioner of insurance, or a designee.

8 18 (2) The director of human services, or a designee.

8 19 (3) The director of public health, or a designee.

8 20 (4) The director of the department of administrative
8 21 services, or a designee.

8 22 (5) Four members of the general assembly, one appointed by
8 23 the speaker of the house of representatives, one appointed by
8 24 the minority leader of the house of representatives, one
8 25 appointed by the majority leader of the senate, and one
8 26 appointed by the minority leader of the senate.

8 27 c. Each member of the board appointed by the governor
8 28 shall be a resident of this state and the composition of
8 29 voting members of the board shall be in compliance with
8 30 sections 69.16, 69.16A, and 69.16C.

8 31 d. The voting members of the board shall be appointed for
8 32 terms of six years beginning and ending as provided in section
8 33 69.19. A member of the board is eligible for reappointment.

8 34 The governor shall fill a vacancy for the remainder of the
8 35 unexpired term. A member of the board may be removed by the
9 1 governor for misfeasance, malfeasance, or willful neglect of
9 2 duty or other cause after notice and a public hearing unless
9 3 the notice and hearing are waived by the member in writing.

9 4 e. The voting members of the board shall annually elect
9 5 one of the members as chairperson and one as vice chairperson.

9 6 f. A majority of the voting members of the board
9 7 constitutes a quorum. The affirmative vote of a majority of
9 8 the voting members is necessary for any action taken by the
9 9 board. The majority shall not include a member who has a
9 10 conflict of interest and a statement by a member of a conflict
9 11 of interest is conclusive for this purpose. A vacancy in the
9 12 voting membership of the board does not impair the right of a

9 13 quorum to exercise the rights and perform the duties of the
9 14 board. An action taken by the board under this chapter may be
9 15 authorized by resolution at a regular or special meeting and
9 16 each resolution shall take effect immediately and need not be
9 17 published or posted. Meetings of the board shall be held at
9 18 the call of the chairperson or at the request of a majority of
9 19 the voting members.

9 20 g. Members of the board may be reimbursed from the moneys
9 21 of the exchange for expenses incurred by them as members, but
9 22 shall not be otherwise compensated by the exchange for their
9 23 services.

9 24 h. The voting members of the board shall give bond as
9 25 required for public officers in chapter 64.

9 26 i. The members of the board are subject to and are
9 27 officials within the meaning of chapter 68B.

9 28 j. All employees of the exchange are exempt from chapter
9 29 8A, subchapter IV, and chapter 97B.

9 30 3. The voting members of the board shall appoint an
9 31 executive director to supervise the administrative affairs and
9 32 general management and operations of the exchange. The
9 33 executive director of the board shall keep a record of the
9 34 proceedings of the board and shall be custodian of all books,
9 35 documents, and papers filed with the board, the minute book or
10 1 journal of the board, and the official seal of the board. The
10 2 executive director may cause copies to be made of minutes and
10 3 other records and documents of the board and may give
10 4 certificates under the official seal of the board that the
10 5 copies are true copies, and persons dealing with the board may
10 6 rely upon the certificates.

10 7 4. The exchange shall be considered a governmental body
10 8 for the purposes of chapter 21 and a government body for the
10 9 purposes of chapter 22.

10 10 Sec. 5. NEW SECTION. 514M.5 PLAN OF OPERATION ==
10 11 ASSESSMENTS.

10 12 1. The exchange shall submit to the commissioner a plan of
10 13 operation for the exchange and any amendments necessary or
10 14 suitable to assure the fair, reasonable, and equitable
10 15 administration of the exchange. The plan of operation shall
10 16 include provisions for the development of a comprehensive
10 17 health care coverage plan as provided in section 514M.6. The
10 18 plan of operation becomes effective upon approval in writing
10 19 by the commissioner prior to the date on which the coverage
10 20 under this chapter must be made available. After notice and
10 21 hearing, the commissioner shall approve the plan of operation
10 22 if the plan is determined to be suitable to assure the fair,
10 23 reasonable, and equitable administration of the exchange, and
10 24 provides for the sharing of exchange losses, if any, on an
10 25 equitable and proportionate basis among the member carriers.
10 26 If the exchange fails to submit a suitable plan of operation
10 27 within one hundred eighty days after the appointment of the
10 28 board of directors, or if at any later time the exchange fails
10 29 to submit suitable amendments to the plan, the commissioner
10 30 shall adopt, pursuant to chapter 17A, rules necessary to
10 31 administer this section. The rules shall continue in force
10 32 until modified by the commissioner or superseded by a plan
10 33 submitted by the exchange and approved by the commissioner.
10 34 In addition to other requirements, the plan of operation shall
10 35 provide for all of the following:

11 1 a. The handling and accounting of assets and moneys of the
11 2 exchange.

11 3 b. The amount and method of reimbursing members of the
11 4 board.

11 5 c. Regular times and places for meetings of the board.

11 6 d. Records to be kept of all financial transactions, and
11 7 the annual fiscal reporting to the commissioner.

11 8 e. The periodic advertising of the general availability of
11 9 health insurance coverage from the exchange.

11 10 f. Additional provisions necessary or proper for the
11 11 execution of the powers and duties of the exchange.

11 12 2. The plan of operation may provide that the powers and
11 13 duties of the exchange may be delegated to a person who will
11 14 perform functions similar to those of the exchange. A
11 15 delegation under this section takes effect only upon the
11 16 approval of both the board and the commissioner. The
11 17 commissioner shall not approve a delegation unless the
11 18 protections afforded to the insureds are substantially
11 19 equivalent to or greater than those provided under this
11 20 chapter.

11 21 3. The exchange has the general powers and authority
11 22 enumerated by this section and executed in accordance with the
11 23 plan of operation approved by the commissioner under

11 24 subsection 1. The exchange has the general powers and
11 25 authority granted under the laws of this state to carriers
11 26 licensed to issue health insurance coverage. In addition, the
11 27 exchange may do any of the following:

11 28 a. Enter into contracts as necessary or proper to carry
11 29 out this chapter.

11 30 b. Sue or be sued, including taking any legal action
11 31 necessary or proper for recovery of any assessments for, on
11 32 behalf of, or against participating carriers.

11 33 c. Take legal action necessary to avoid the payment of
11 34 improper claims against the exchange or the coverage provided
11 35 by or through the exchange.

12 1 d. Establish or utilize a medical review committee to
12 2 determine the reasonably appropriate level and extent of
12 3 health care services in each instance.

12 4 e. Establish appropriate rates, scales of rates, rate
12 5 classifications, and rating adjustments, which rates shall not
12 6 be unreasonable in relation to the health care coverage
12 7 provided and the reasonable operations expenses of the
12 8 exchange.

12 9 f. Pool risks among members.

12 10 g. Issue exchange policies on an indemnity or provision of
12 11 service basis providing the health care coverage required by
12 12 this chapter.

12 13 h. Administer separate pools, separate accounts, or other
12 14 plans or arrangements considered appropriate for separate
12 15 members or groups of members.

12 16 i. Operate and administer any combination of plans, pools,
12 17 or other mechanisms considered appropriate to best accomplish
12 18 the fair and equitable operation of the exchange.

12 19 j. Appoint from among members appropriate legal,
12 20 actuarial, and other committees as necessary to provide
12 21 technical assistance in the operation of the exchange, policy
12 22 and other contract design, and any other functions within the
12 23 authority of the exchange.

12 24 k. Hire independent consultants as necessary.

12 25 l. Develop a method of advising applicants of the
12 26 availability of other health care coverages outside the
12 27 exchange.

12 28 m. Include in its policies a provision providing for
12 29 subrogation rights by the exchange in a case in which the
12 30 exchange pays expenses on behalf of an individual who is
12 31 injured or suffers a disease under circumstances creating a
12 32 liability upon another person to pay damages to the extent of
12 33 the expenses paid by the exchange but only to the extent the
12 34 damages exceed the policy deductible and coinsurance amounts
12 35 paid by the insured. The exchange may waive its subrogation
13 1 rights if it determines that the exercise of the rights would
13 2 be impractical, uneconomical, or would work a hardship on the
13 3 insured.

13 4 n. Establish lines of credit, and establish one or more
13 5 cash and investment accounts to receive payments for services
13 6 rendered, appropriations from the state, and all other
13 7 business activity granted by this chapter except to the extent
13 8 otherwise limited by any applicable provision of the federal
13 9 Employee Retirement Income Security Act of 1974.

13 10 o. Design and approve the use of its trademarks, brand
13 11 names, seals, logos, and similar instruments by participating
13 12 carriers, employers, or organizations.

13 13 p. Enter into agreements with the department of revenue,
13 14 the department of human services, the division of insurance,
13 15 and any other state agencies the exchange deems necessary to
13 16 administer its duties under this chapter.

13 17 q. Seek and receive any grant funding from the federal
13 18 government, departments or agencies of the state, and private
13 19 foundations.

13 20 4. Following the close of each calendar year, the exchange
13 21 shall determine the net premiums and payments, the expenses of
13 22 administration, and the incurred losses of the exchange for
13 23 the year. The exchange shall certify the amount of any net
13 24 loss for the preceding calendar year to the commissioner and
13 25 director of revenue. Any loss shall be assessed by the
13 26 exchange to all members of the exchange in proportion to their
13 27 respective shares of total health insurance premiums or
13 28 payments for subscriber contracts received in Iowa during the
13 29 second preceding calendar year, or with paid losses in the
13 30 year, coinciding with or ending during the calendar year or on
13 31 any other equitable basis as provided in the plan of
13 32 operation. In sharing losses, the exchange may abate or defer
13 33 in any part the assessment of a member, if, in the opinion of
13 34 the board, payment of the assessment would endanger the

13 35 ability of the member to fulfill its contractual obligations.
14 1 The exchange may also provide for an initial or interim
14 2 assessment against members of the exchange if necessary to
14 3 assure the financial capability of the exchange to meet the
14 4 incurred or estimated claims expenses or operating expenses of
14 5 the exchange until the next calendar year is completed. Net
14 6 gains, if any, must be held at interest to offset future
14 7 losses or allocated to reduce future premiums.

14 8 a. For purposes of this subsection, "total health
14 9 insurance premiums" and "payments for subscriber contracts"
14 10 include, without limitation, premiums or other amounts paid to
14 11 or received by a member for individual and group health plan
14 12 coverage provided under any chapter of the Code or Acts, and
14 13 "paid losses" includes, without limitation, claims paid by a
14 14 member operating on a self-funded basis for individual and
14 15 group health plan coverage provided under any chapter of the
14 16 Code or Acts.

14 17 b. For purposes of calculating and conducting the
14 18 assessment under this subsection, the exchange shall have the
14 19 express authority to require members to report on an annual
14 20 basis each member's total health insurance premiums and
14 21 payments for subscriber contracts and paid losses. A member
14 22 is liable for its share of the assessment calculated in
14 23 accordance with this section regardless of whether it
14 24 participates in the individual insurance market.

14 25 5. The exchange shall conduct annual audits to assure the
14 26 general accuracy of the financial data submitted to the
14 27 exchange, and the exchange shall have an annual audit of its
14 28 operations, made by an independent certified public
14 29 accountant.

14 30 6. The exchange is subject to examination by the
14 31 commissioner. Not later than April 30 of each year, the board
14 32 shall submit to the commissioner a financial report for the
14 33 preceding calendar year in a form approved by the
14 34 commissioner.

14 35 7. The exchange is subject to oversight by the legislative
15 1 fiscal committee of the legislative council. Not later than
15 2 April 30 of each year, the board shall submit to the governor,
15 3 the speaker of the house of representatives, the majority
15 4 leader of the senate, and the legislative fiscal committee a
15 5 financial report, including enrollment information, for the
15 6 preceding year in a form approved by the committee.

15 7 8. All policy forms issued by the exchange must be filed
15 8 with and approved by the commissioner before their use.

15 9 9. The exchange is exempt from payment of all fees and all
15 10 taxes levied by this state or any of its political
15 11 subdivisions.

15 12 10. The exchange shall develop and implement a plan and
15 13 corresponding timeline detailing action steps toward
15 14 implementing this chapter, by rules adopted pursuant to
15 15 chapter 17A as provided in section 514M.7.

15 16 Sec. 6. NEW SECTION. 514M.6 IOWA CHOICE INSURANCE
15 17 EXCHANGE COVERAGE.

15 18 1. The exchange, in collaboration with the Iowa Medicaid
15 19 enterprise and the hawk=i board, shall develop a comprehensive
15 20 health care coverage plan to provide health care coverage to
15 21 all children without such coverage, that utilizes and modifies
15 22 existing public programs including the medical assistance
15 23 program and hawk=i program and maximizes the ability of the
15 24 state to obtain federal funding and reimbursement for such
15 25 programs. The plan shall also provide access to private
15 26 unsubsidized, affordable, qualified health care coverage to
15 27 children who are not otherwise eligible for health care
15 28 coverage through public programs.

15 29 2. The comprehensive plan developed by the exchange shall
15 30 also consider and recommend options to provide access to
15 31 private unsubsidized, affordable, qualified health care
15 32 coverage to all Iowa children less than nineteen years of age
15 33 with a family income that is more than three hundred percent
15 34 of the federal poverty level and to adults and families with a
15 35 family income that is up to four hundred percent of the
16 1 federal poverty level who are not otherwise eligible for
16 2 health care coverage through public programs.

16 3 3. The comprehensive plan developed by the exchange shall
16 4 also consider and recommend options to offer a program to
16 5 provide coverage under the state health or medical group
16 6 insurance plan to nonstate public employees, including
16 7 employees of counties, cities, schools, and community
16 8 colleges, and employees of nonprofit employers and small
16 9 employers and to pool such employees with the state plan. The
16 10 program developed shall allow employees and officials of such

16 11 employers who apply for coverage to be covered under the state
16 12 plan under the same conditions that state employees are
16 13 covered under the state plan and not be denied coverage on the
16 14 basis of risk, cost, preexisting conditions, or other factors
16 15 not applicable to state employees. The plan may include
16 16 options for the coverage of such employees and officials under
16 17 the state plan that include but are not limited to the
16 18 following:

- 16 19 a. Criteria for participation in and withdrawal from the
16 20 program.
- 16 21 b. Minimum participation intervals.
- 16 22 c. Collaboration with the department of administrative
16 23 services to develop coverage options for coverage from vendors
16 24 other than those providing coverage to state employees and
16 25 under plans different from those available to state employees,
16 26 that meet minimum standards of quality and affordability.
- 16 27 d. Application and enrollment procedures.
- 16 28 e. Premium rates and procedures for the payment of
16 29 premiums by participants.

16 30 4. The exchange shall have broad authority to accomplish
16 31 the purposes of this chapter, including but not limited to:

16 32 a. Establishing, by rule, what constitutes qualified
16 33 health care coverage within parameters set by statute which
16 34 may include consideration of the following factors:

16 35 (1) Setting parameters for what is affordable by creating
17 1 an affordability schedule that is conservative to prevent harm
17 2 to people who are struggling financially and that utilizes a
17 3 progressive scale of subsidization by the state that decreases
17 4 as incomes increase and requires people with very low incomes
17 5 to pay only small amounts for health care coverage with no
17 6 financial penalties.

17 7 (2) Setting the maximum limit for affordability of
17 8 coverage at approximately six and one-half percent of an
17 9 individual's or family's income, including consideration of
17 10 assets held.

17 11 b. Establishing what constitutes qualified health care
17 12 coverage which meets certain standards of quality and
17 13 affordability. For purposes of defining qualified health care
17 14 coverage, the board may consider requirements for coverage and
17 15 benefits that include but are not limited to:

17 16 (1) No underwriting requirements and no preexisting
17 17 condition exclusions.

17 18 (2) Portability.

17 19 (3) Coverage of physical, behavioral, and dental health
17 20 services, vision services, and prescription drugs.

17 21 (4) Copayments and deductibles that do not exceed
17 22 specified amounts, with no copayments or deductibles for
17 23 wellness, prevention, disease, and chronic care management
17 24 services.

17 25 (5) No reimbursement of providers for an otherwise covered
17 26 service if the service is required solely on account of the
17 27 provider's avoidable medical error.

17 28 (6) A requirement that all insureds have a medical home.

17 29 (7) Coverage of wellness, prevention, disease management,
17 30 and chronic care management services including, without
17 31 limitation, physical and psycho-social screenings for children
17 32 which satisfy the Medicaid early periodic screening,
17 33 diagnosis, and treatment standards.

17 34 (8) Coverage of emergency mental health services when
17 35 provided by a state-certified emergency mental health services
18 1 provider.

18 2 (9) Incentives for participating health care providers
18 3 that:

18 4 (a) Utilize electronic prescriptions.

18 5 (b) Utilize electronic medical records.

18 6 (c) Provide rate schedules of all services provided to the
18 7 board.

18 8 c. Establishing threshold requirements for a future
18 9 mandate to provide health care coverage that must be met by
18 10 parents of children less than nineteen years of age with
18 11 family incomes greater than three hundred percent of the
18 12 federal poverty level.

18 13 d. Collaborating with carriers to do the following,
18 14 including but not limited to:

18 15 (1) Assuring the availability of private health insurance
18 16 coverage to all Iowans by designing solutions to issues
18 17 related to guaranteed issuance of insurance, preexisting
18 18 condition exclusions, portability, and allowable pooling and
18 19 rating classifications.

18 20 (2) Formulating principles that ensure fair and
18 21 appropriate practices related to issues involving individual

18 22 health insurance policies such as rescission and preexisting
18 23 condition clauses, and that provide for a binding third party
18 24 review process to resolve disputes related to such issues.
18 25 (3) Designing affordable, portable health insurance plans
18 26 that meet the needs of low-income populations.
18 27 5. The exchange shall design and implement a health care
18 28 coverage program called Iowa choice which offers private
18 29 qualified health care coverage through the exchange with
18 30 options to purchase at least three levels of benefits
18 31 including a gold plan which offers a comprehensive benefits
18 32 package, a silver plan which offers a medium benefits package,
18 33 and a bronze plan which offers a basic benefits package. The
18 34 Iowa choice care plans shall be available for purchase by
18 35 individuals and families. The purchase of Iowa choice health
19 1 care coverage may be publicly subsidized for low-income
19 2 individuals and families who do not meet eligibility
19 3 guidelines for any other public program. Iowa choice health
19 4 care coverage shall also provide affordable, unsubsidized
19 5 qualified health care coverage options for purchase by any
19 6 person who wishes to purchase them, including individuals,
19 7 families, and employees of small businesses.
19 8 6. The exchange shall design and administer a subsidy
19 9 program for payment of premiums for health care coverage for
19 10 low-income people that complements, not supplants, Medicaid
19 11 and includes cost-sharing by the insured using a sliding scale
19 12 based on income utilizing the federal poverty level
19 13 guidelines. The subsidy program may include subsidizing an
19 14 employee's purchase of health insurance offered by that
19 15 person's employer. The subsidy program may be implemented
19 16 incrementally as funding becomes available and may include
19 17 rolling implementation of the program to specified subgroups
19 18 of low-income children, adults, and families with incomes up
19 19 to four hundred percent of the federal poverty level.
19 20 7. The exchange shall provide for the coordination of a
19 21 children's health care network in the state that acts as a
19 22 resource for consumers to transition seamlessly among public
19 23 and private health care coverage options, including but not
19 24 limited to medical assistance, hawk=i, and Iowa choice care
19 25 programs.
19 26 8. The exchange shall conduct a study of the cost to the
19 27 state of providing public health care coverage to undocumented
19 28 children including information concerning how many
19 29 undocumented children live in the state, where the
19 30 undocumented children live, and a comparison of the social and
19 31 economic impacts of providing or not providing public health
19 32 care coverage to such children.
19 33 9. The exchange shall conduct a study of pharmacy benefits
19 34 managers in the state to review all of the following:
19 35 a. Transparency and disclosure arrangements between
20 1 pharmacy benefits managers and covered entities.
20 2 b. Confidentiality protections for information disclosed
20 3 to covered entities and remedies for unauthorized disclosure.
20 4 c. The ability of covered entities to audit pharmacy
20 5 benefits managers.
20 6 d. Appropriate remedies for covered entities to enforce a
20 7 provision of or for a violation of a provision of chapter
20 8 510B, as amended in this Act.
20 9 10. The exchange shall implement initiatives such as
20 10 uniform insurance applications, uniform billing and coding
20 11 procedures in Iowa choice plans, and other standardized
20 12 administrative procedures that make the purchase of insurance
20 13 easier and lower administrative costs. The board may
20 14 determine what constitutes an equitable administrative formula
20 15 for carriers.
20 16 11. The exchange shall encourage initiatives that allow
20 17 portability of insurance plans offered by the exchange.
20 18 12. The exchange may set and control premiums by
20 19 establishing what constitutes reasonable rates to ensure
20 20 affordability of coverage.
20 21 13. The exchange shall study the ramifications of
20 22 requiring each employer with more than ten employees in the
20 23 state to adopt and maintain a cafeteria plan that satisfies
20 24 section 125 of the federal Internal Revenue Code of 1986, and
20 25 the rules adopted by the exchange.
20 26 14. The exchange shall establish procedures for the
20 27 selection and approval of qualified health care coverage plans
20 28 to be offered through the exchange.
20 29 15. The exchange shall establish procedures for the
20 30 enrollment of eligible individuals and groups.
20 31 16. The exchange shall establish procedures for appeals of
20 32 eligibility decisions for the Iowa choice insurance exchange.

20 33 17. The exchange shall operate a health insurance service
20 34 center that collects and distributes information to consumers
20 35 about all health insurance policies, contracts, and plans
21 1 available in the state and provides information to eligible
21 2 Iowans about the exchange.

21 3 18. The exchange shall establish and manage a system of
21 4 collecting all premium payments made by, or on behalf of,
21 5 individuals obtaining health insurance through the exchange,
21 6 including any premium payments made by enrollees, employers,
21 7 unions, or other organizations.

21 8 19. The exchange shall establish and manage a system of
21 9 remitting premium assistance payments to the carriers.

21 10 20. The exchange shall establish a plan for publicizing
21 11 the existence of the exchange and the exchange's requirements
21 12 and enrollment procedures.

21 13 21. The exchange shall develop criteria for determining
21 14 that certain health insurance plans shall no longer be made
21 15 available through the exchange, and develop a plan to
21 16 decertify and remove exchange approval from certain health
21 17 benefit plans.

21 18 22. The exchange shall develop criteria for health
21 19 insurance plans eligible for premium assistance payments
21 20 through the Iowa choice insurance exchange.

21 21 23. The exchange shall establish criteria for determining
21 22 each applicant's eligibility to purchase health insurance
21 23 offered by the exchange, including eligibility for premium
21 24 assistance payments.

21 25 24. The exchange shall establish criteria for insurance
21 26 producers licensed under chapter 522B to sell private health
21 27 care coverage offered through the exchange, including the
21 28 amount of commission which may be earned for sales of such
21 29 coverage.

21 30 25. The exchange may contract with professional service
21 31 firms as deemed necessary to carry out the requirements of
21 32 this section, and fix their compensation.

21 33 26. The exchange may contract with companies which provide
21 34 third-party administrative and billing services for health
21 35 insurance products.

22 1 27. The exchange shall design a premium schedule to be
22 2 published by the exchange by December 1 of each year, which,
22 3 accounting for maximum pricing in all rating factors with an
22 4 exception for age, includes the lowest premium on the market
22 5 for which an individual would be eligible for qualified health
22 6 care coverage as determined by the board. The schedule shall
22 7 publish premiums allowing variance for age and rate basis
22 8 type.

22 9 Sec. 7. NEW SECTION. 514M.7 RULES.

22 10 The commissioner and the board shall adopt rules pursuant
22 11 to chapter 17A, to implement the provisions of this chapter.

22 12 Sec. 8. NEW SECTION. 514M.8 IOWA CHOICE INSURANCE
22 13 EXCHANGE FUND ESTABLISHED.

22 14 1. The Iowa choice insurance exchange fund is created in
22 15 the state treasury as a separate fund under the control of the
22 16 exchange. There shall be credited to the fund all moneys
22 17 collected from premiums paid for health care plans offered by
22 18 the exchange, and any other funds that are appropriated or
22 19 transferred to the fund. All moneys deposited or paid into
22 20 the fund shall only be appropriated to the exchange to be used
22 21 for the purposes set forth in this chapter.

22 22 2. Notwithstanding section 8.33, any balance in the fund
22 23 on June 30 of each fiscal year shall not revert to the general
22 24 fund of the state, but shall be available for purposes of this
22 25 chapter in subsequent fiscal years.

22 26 Sec. 9. NEW SECTION. 514M.9 COLLECTIVE ACTION ==
22 27 IMMUNITY.

22 28 Neither the participation by carriers or members in the
22 29 exchange, the establishment of rates, forms, or procedures for
22 30 coverage issued by the exchange, nor any joint or collective
22 31 action required by this chapter shall be the basis of any
22 32 legal civil action, or criminal liability against the exchange
22 33 or members of it either jointly or separately.

22 34 Sec. 10. NEW SECTION. 514M.10 UNIVERSAL HEALTH CARE
22 35 COVERAGE == TRANSITION == IMPLEMENTATION.

23 1 1. To protect the health of all Iowans, the board shall
23 2 design and implement a program, including a timetable and
23 3 procedures for implementation, to ensure that all children in
23 4 the state have qualified health care coverage by maximizing
23 5 the use of state and private financial support as follows:

23 6 a. All children who are eligible for Medicaid and hawk=i
23 7 shall have coverage by December 31, 2010. Parents of such
23 8 children shall provide proof that each child has qualified

23 9 health care coverage at a time and in a manner as specified by
23 10 the board by rule. Implementation of this requirement may
23 11 include a reporting requirement on Iowa income tax returns or
23 12 during school registration.

23 13 b. As funding becomes available, the state shall provide a
23 14 subsidy to assist with the purchase of qualified health care
23 15 coverage for the remaining uninsured children up to nineteen
23 16 years of age with a family income of up to four hundred
23 17 percent of the federal poverty level, using a sliding scale
23 18 based on family income. Parents of such children who are
23 19 eligible for subsidies shall provide proof that each child has
23 20 qualified health care coverage, at a time and in a manner as
23 21 specified by the board by rule. Implementation of this
23 22 requirement may include a reporting requirement on Iowa income
23 23 tax returns or during school registration.

23 24 c. All parents of children less than nineteen years of age
23 25 shall be required to provide proof that each child has
23 26 qualified health care coverage, at a time and in a manner as
23 27 specified by the board by rule. Implementation of this
23 28 requirement shall include a reporting requirement on Iowa
23 29 income tax returns or during school registration.

23 30 2. To protect the health of all Iowans, the board shall
23 31 design and implement a program, including a timetable and
23 32 procedures for implementation after all children have
23 33 qualified health care coverage, to ensure that all adults in
23 34 the state have qualified health care coverage as follows:

23 35 a. The state shall continue to expand options for
24 1 individuals who are dually eligible for Medicare and Medicaid
24 2 by utilizing evidence-based care.

24 3 b. As funding becomes available, the state shall provide a
24 4 subsidy to assist uninsured health and long-term care workers
24 5 with the purchase of qualified health care coverage. "Health
24 6 and long-term care workers" shall be defined by the board by
24 7 rules adopted under chapter 17A. A health or long-term care
24 8 worker who is eligible for the subsidy shall provide proof of
24 9 qualified health care coverage, at a time and in a manner as
24 10 specified by the board by rule. Implementation of this
24 11 requirement may include a reporting requirement on Iowa income
24 12 tax returns.

24 13 c. As funding becomes available, the state shall provide a
24 14 subsidy to assist with the purchase of qualified health care
24 15 coverage by the remaining uninsured adults with a family
24 16 income of up to four hundred percent of the federal poverty
24 17 level, using a sliding scale based on income. A person who is
24 18 eligible for the subsidy shall provide proof of qualified
24 19 health care coverage, at a time and in a manner as specified
24 20 by the board by rule. Implementation of this requirement may
24 21 include a reporting requirement on Iowa income tax returns.

24 22 d. All adults shall be required to provide proof of
24 23 qualified health care coverage, at a time and in a manner as
24 24 specified by the board by rule. Implementation of this
24 25 requirement may include a reporting requirement on Iowa income
24 26 tax returns.

24 27 3. An adult or parent of a child who is required to
24 28 provide proof of qualified health care coverage of the adult
24 29 or child and does not do so shall automatically be assigned
24 30 and enrolled in the appropriate health care coverage program
24 31 at a cost and in a time and manner determined by the board by
24 32 rule.

24 33 4. The board shall collaborate with the department of
24 34 human services, the insurance division of the department of
24 35 commerce, and with members of the exchange to institute health
25 1 insurance reforms that may become effective once universal
25 2 health coverage of all Iowans has been achieved. Such reforms
25 3 may include:

25 4 a. Carriers will enroll any applicant rated up to two
25 5 hundred percent of standard at a maximum premium rate of one
25 6 hundred fifty percent of the standard rate.

25 7 b. Any applicant rated over two hundred percent of
25 8 standard will be enrolled in a plan offered by the state, such
25 9 as the Iowa comprehensive health insurance association pool or
25 10 the Iowa choice insurance exchange pool or a combination
25 11 thereof at one hundred fifty percent of standard premium rates
25 12 with the state subsidizing any cost over that amount.

25 13 c. Carriers will offer open enrollment periods where any
25 14 applicant may enroll with no preexisting condition exclusions.

25 15 d. Carriers will guarantee issuance of insurance with no
25 16 preexisting condition exclusions if an applicant has no more
25 17 than sixty-three days of lapse of coverage.

25 18 5. The Iowa choice insurance exchange program shall be
25 19 implemented by the board by rule pursuant to chapter 17A in

25 20 accordance with parameters and schedules established by
25 21 statute. The administrative rules review committee may
25 22 provide oversight of the rules through the administrative
25 23 rulemaking process.

25 24 COORDINATING AMENDMENTS

25 25 Sec. 11. Section 21.2, subsection 1, Code 2009, is amended
25 26 by adding the following new paragraph:

25 27 NEW PARAGRAPH. i. A nonprofit corporation established
25 28 pursuant to chapter 514M.

25 29 Sec. 12. Section 22.1, subsection 1, Code 2009, is amended
25 30 to read as follows:

25 31 1. The term "government body" means this state, or any
25 32 county, city, township, school corporation, political
25 33 subdivision, tax-supported district, nonprofit corporation
25 34 other than a fair conducting a fair event as provided in
25 35 chapter 174, whose facilities or indebtedness are supported in
26 1 whole or in part with property tax revenue and which is
26 2 licensed to conduct pari-mutuel wagering pursuant to chapter
26 3 99D, nonprofit corporation established pursuant to chapter
26 4 514M, or other entity of this state, or any branch,
26 5 department, board, bureau, commission, council, committee,
26 6 official, or officer of any of the foregoing or any employee
26 7 delegated the responsibility for implementing the requirements
26 8 of this chapter.

26 9 Sec. 13. Section 514E.1, subsections 15 and 22, Code 2009,
26 10 are amended by striking the subsections.

26 11 Sec. 14. Section 514E.2, subsection 3, unnumbered
26 12 paragraph 1, Code 2009, is amended to read as follows:

26 13 The association shall submit to the commissioner a plan of
26 14 operation for the association and any amendments necessary or
26 15 suitable to assure the fair, reasonable, and equitable
26 16 administration of the association. ~~The plan of operation~~
~~26 17 shall include provisions for the development of a~~
~~26 18 comprehensive health care coverage plan as provided in section~~
~~26 19 514E.5. In developing the comprehensive plan the association~~
~~26 20 shall give deference to the recommendations made by the~~
~~26 21 advisory council as provided in section 514E.6, subsection 1.~~
~~26 22 The association shall approve or disapprove but shall not~~
~~26 23 modify recommendations made by the advisory council.~~

~~26 24 Recommendations that are approved shall be included in the~~
~~26 25 plan of operation submitted to the commissioner.~~

~~26 26 Recommendations that are disapproved shall be submitted to the~~
~~26 27 commissioner with reasons for the disapproval. The plan of~~

26 28 operation becomes effective upon approval in writing by the
26 29 commissioner prior to the date on which the coverage under
26 30 this chapter must be made available. After notice and
26 31 hearing, the commissioner shall approve the plan of operation
26 32 if the plan is determined to be suitable to assure the fair,
26 33 reasonable, and equitable administration of the association,
26 34 and provides for the sharing of association losses, if any, on
26 35 an equitable and proportionate basis among the member
27 1 carriers. If the association fails to submit a suitable plan
27 2 of operation within one hundred eighty days after the
27 3 appointment of the board of directors, or if at any later time
27 4 the association fails to submit suitable amendments to the
27 5 plan, the commissioner shall adopt, pursuant to chapter 17A,
27 6 rules necessary to implement this section. The rules shall
27 7 continue in force until modified by the commissioner or
27 8 superseded by a plan submitted by the association and approved
27 9 by the commissioner. In addition to other requirements, the
27 10 plan of operation shall provide for all of the following:

27 11 Sec. 15. Sections 514E.5 and 514E.6, Code 2009, are
27 12 repealed.

27 13 DIVISION II

27 14 HEALTH CARE COVERAGE OF ADULT CHILDREN

27 15 Sec. 16. Section 422.7, Code 2009, is amended by adding
27 16 the following new subsection:

27 17 NEW SUBSECTION. 29A. If the health benefits coverage or
27 18 insurance of the taxpayer includes coverage of a nonqualified
27 19 tax dependent as determined by the federal internal revenue
27 20 service, subtract, to the extent included, the amount of the
27 21 value of such coverage attributable to the nonqualified tax
27 22 dependent.

27 23 Sec. 17. Section 509.3, subsection 8, Code 2009, is
27 24 amended to read as follows:

27 25 8. A provision that the insurer will permit continuation
27 26 of existing coverage or reenrollment in previously existing
27 27 coverage for an unmarried child of an insured or enrollee who
27 28 so elects, at least through the policy anniversary date on or
27 29 after the date the child marries, ceases to be a resident of
27 30 this state, or attains the age of twenty-five years old,

27 31 whichever occurs first, or so long as the unmarried child
27 32 maintains full-time status as a student in an accredited
27 33 institution of postsecondary education.
27 34 In addition to the provisions required in subsections 1
27 35 through 7, the commissioner shall require provisions through
28 1 the adoption of rules implementing the federal Health
28 2 Insurance Portability and Accountability Act, Pub. L. No.
28 3 104=191.

28 4 Sec. 18. Section 509A.13B, Code 2009, is amended to read
28 5 as follows:
28 6 509A.13B ~~CONTINUATION OF DEPENDENT COVERAGE OF CHILDREN ==~~
28 7 ~~CONTINUATION OR REENROLLMENT.~~

28 8 If a governing body, a county board of supervisors, or a
28 9 city council has procured accident or health care coverage for
28 10 its employees under this chapter such coverage shall permit
28 11 continuation of existing coverage or reenrollment in
28 12 previously existing coverage for an unmarried child of an
28 13 insured or enrollee who so elects, at least through the policy
28 14 anniversary date on or after the date the child marries,
28 15 ceases to be a resident of this state, or attains the age of
28 16 twenty-five years old, whichever occurs first, or so long as
28 17 the unmarried child maintains full-time status as a student in
28 18 an accredited institution of postsecondary education.

28 19 Sec. 19. Section 514A.3B, subsection 2, Code 2009, is
28 20 amended to read as follows:

28 21 2. An insurer issuing an individual policy or contract of
28 22 accident and health insurance which provides coverage for
28 23 children of the insured shall permit continuation of existing
28 24 coverage or reenrollment in previously existing coverage for
28 25 an unmarried child of an insured or enrollee who so elects, at
28 26 least through the policy anniversary date on or after the date
28 27 the child marries, ceases to be a resident of this state, or
28 28 attains the age of twenty-five years old, whichever occurs
28 29 first, or so long as the unmarried child maintains full-time
28 30 status as a student in an accredited institution of
28 31 postsecondary education.

28 32 Sec. 20. APPLICABILITY. The sections of this Act amending
28 33 section 509.3, subsection 8, 509A.13B, and 514A.3B, subsection
28 34 2, apply to policies, contracts, or plans of accident and
28 35 health insurance delivered, issued for delivery, continued, or
29 1 renewed in this state on or after July 1, 2009.

29 2 Sec. 21. RETROACTIVE APPLICABILITY DATE. The section of
29 3 this Act enacting section 422.7, subsection 29A, applies
29 4 retroactively to January 1, 2009, for tax years beginning on
29 5 or after that date.

29 6
29 7 DIVISION III
29 8 MEDICAL ASSISTANCE AND HAWK=I PROVISIONS
29 9 COVERAGE FOR ALL INCOME=ELIGIBLE CHILDREN

29 9 Sec. 22. NEW SECTION. 249A.3A MEDICAL ASSISTANCE == ALL
29 10 INCOME=ELIGIBLE CHILDREN.

29 11 The department shall provide medical assistance to
29 12 individuals under nineteen years of age who meet the income
29 13 eligibility requirements for the state medical assistance
29 14 program and for whom federal financial participation is or
29 15 becomes available for the cost of such assistance.

29 16 Sec. 23. NEW SECTION. 514I.8A HAWK=I == ALL
29 17 INCOME=ELIGIBLE CHILDREN.

29 18 The department shall provide coverage to individuals under
29 19 nineteen years of age who meet the income eligibility
29 20 requirements for the hawk=i program and for whom federal
29 21 financial participation is or becomes available for the cost
29 22 of such coverage.

29 23 REQUIRED APPLICATION FOR DEPENDENT CHILD HEALTH CARE COVERAGE
29 24 Sec. 24. Section 422.12M, Code 2009, is amended to read as
29 25 follows:

29 26 422.12M INCOME TAX FORM == INDICATION OF DEPENDENT CHILD
29 27 HEALTH CARE COVERAGE.

29 28 1. The director shall draft the income tax form to allow
29 29 require beginning with the tax returns for tax year ~~2008~~ 2010,
29 30 a person who files an individual or joint income tax return
29 31 with the department under section 422.13 to indicate the
29 32 presence or absence of health care coverage for each dependent
29 33 child for whom an exemption is claimed.

29 34 2. Beginning with the income tax return for tax year ~~2008~~
29 35 2010, a person who files an individual or joint income tax
30 1 return with the department under section 422.13, may shall
30 2 report on the income tax return, in the form required, the
30 3 presence or absence of health care coverage for each dependent
30 4 child for whom an exemption is claimed.

30 5 a. If the taxpayer indicates on the income tax return that
30 6 a dependent child does not have health care coverage, and the

30 7 income of the taxpayer's tax return does not exceed the
30 8 highest level of income eligibility standard for the medical
30 9 assistance program pursuant to chapter 249A or the hawk=i
30 10 program pursuant to chapter 514I, the department shall send a
30 11 notice to the taxpayer indicating that the dependent child may
30 12 be eligible for the medical assistance program or the hawk=i
30 13 program and providing information to the taxpayer about how to
30 14 enroll the dependent child in the programs appropriate
30 15 program. The taxpayer shall submit an application for the
30 16 appropriate program within ninety days of receipt of the
30 17 enrollment information.

~~30 18 b. Notwithstanding any other provision of law to the
30 19 contrary, a taxpayer shall not be subject to a penalty for not
30 20 providing the information required under this section.~~

30 21 e. ~~b.~~ The department shall consult with the department of
30 22 human services in developing the tax return form and the
30 23 information to be provided to tax filers under this section.

30 24 3. The department, in cooperation with the department of
30 25 human services, shall adopt rules pursuant to chapter 17A to
30 26 administer this section, including rules defining "health care
30 27 coverage" for the purpose of indicating its presence or
30 28 absence on the tax form and enforcement provisions relating to
30 29 the required indication of a dependent child's health care
30 30 coverage status on the tax form and the required application
30 31 for an appropriate program as specified in this section.

30 32 4. The department, in cooperation with the department of
30 33 human services, shall report, annually, to the governor and
30 34 the general assembly all of the following:

30 35 a. The number of Iowa families, by income level, claiming
31 1 the state income tax exemption for dependent children.

31 2 b. The number of Iowa families, by income level, claiming
31 3 the state income tax exemption for dependent children ~~who also~~
31 4 and whether they indicate the presence or absence of health
31 5 care coverage for the dependent children.

31 6 c. The effect of the reporting requirements and provision
31 7 of information ~~requirements required~~ under this section on the
31 8 number and percentage of children in the state who are
31 9 uninsured.

31 10 d. The number of those indicating the absence of coverage
31 11 who comply or do not comply with the requirement for
31 12 application for an appropriate program, and any enforcement
31 13 action taken.

31 14 PREGNANT WOMEN INCOME ELIGIBILITY FOR MEDICAID
31 15 Sec. 25. Section 249A.3, subsection 1, paragraph 1, Code
31 16 2009, is amended to read as follows:

31 17 1. (1) Is an infant whose income is not more than two
31 18 hundred percent of the federal poverty level, as defined by
31 19 the most recently revised income guidelines published by the
31 20 United States department of health and human services.

31 21 (2) Additionally, effective July 1, 2009, medical
31 22 assistance shall be provided to ~~an a pregnant woman or~~ infant
31 23 whose family income is at or below three hundred percent of
31 24 the federal poverty level, as defined by the most recently
31 25 revised poverty income guidelines published by the United
31 26 States department of health and human services, if otherwise
31 27 eligible.

31 28 Sec. 26. Section 514I.8, subsection 1, Code 2009, is
31 29 amended to read as follows:

31 30 1. Effective July 1, 1998, and notwithstanding any medical
31 31 assistance program eligibility criteria to the contrary,
31 32 medical assistance shall be provided to, or on behalf of, an
31 33 eligible child under the age of nineteen whose family income
31 34 does not exceed one hundred thirty-three percent of the
31 35 federal poverty level, as defined by the most recently revised
32 1 poverty income guidelines published by the United States
32 2 department of health and human services. Additionally,
32 3 effective July 1, 2000, and notwithstanding any medical
32 4 assistance program eligibility criteria to the contrary,
32 5 medical assistance shall be provided to, or on behalf of, an
32 6 eligible infant whose family income does not exceed two
32 7 hundred percent of the federal poverty level, as defined by
32 8 the most recently revised poverty income guidelines published
32 9 by the United States department of health and human services.

32 10 Effective July 1, 2009, and notwithstanding any medical
32 11 assistance program eligibility criteria to the contrary,
32 12 medical assistance shall be provided to, or on behalf of, a
32 13 pregnant woman or an eligible child who is an infant and whose
32 14 family income is at or below three hundred percent of the
32 15 federal poverty level, as defined by the most recently revised
32 16 poverty income guidelines published by the United States
32 17 department of health and human services.

32 18 IMPROVING ACCESS AND RETENTION

32 19 Sec. 27. Section 249A.4, Code 2009, is amended by adding
32 20 the following new subsection:

32 21 NEW SUBSECTION. 16. Implement the premium assistance
32 22 program options described under the federal Children's Health
32 23 Insurance Program Reauthorization Act of 2009, Pub. L. No.
32 24 111-3, for the medical assistance program. The department may
32 25 adopt rules as necessary to administer these options.

32 26 Sec. 28. Section 513C.3, subsections 14 and 15, Code 2009,
32 27 are amended to read as follows:

32 28 14. "Qualifying event" means any of the following:

32 29 a. Loss of eligibility for medical assistance provided
32 30 pursuant to chapter 249A, coverage provided pursuant to
32 31 chapter 514I, or Medicare coverage provided pursuant to Title

32 32 XVIII of the federal Social Security Act.

32 33 b. Loss or change of dependent status under qualifying
32 34 previous coverage.

32 35 c. The attainment by an individual of the age of majority.

33 1 d. Loss of eligibility for the hawk=i program authorized
33 2 in chapter 514I.

33 3 15. a. "Qualifying existing coverage" or "qualifying
33 4 previous coverage" means benefits or coverage provided under
33 5 any of the following:

33 6 ~~a-~~ (1) Any group health insurance that provides benefits
33 7 similar to or exceeding benefits provided under the standard
33 8 health benefit plan, provided that such policy has been in
33 9 effect for a period of at least one year.

33 10 ~~b-~~ (2) An individual health insurance benefit plan,
33 11 including coverage provided under a health maintenance
33 12 organization contract, a hospital or medical service plan
33 13 contract, or a fraternal benefit society contract, that
33 14 provides benefits similar to or exceeding the benefits
33 15 provided under the standard health benefit plan, provided that
33 16 such policy has been in effect for a period of at least one
33 17 year.

33 18 ~~c-~~ (3) An organized delivery system that provides benefits
33 19 similar to or exceeding the benefits provided under the
33 20 standard health benefit plan, provided that the benefits
33 21 provided by the organized delivery system have been in effect
33 22 for a period of at least one year.

33 23 (4) Coverage provided under chapter 249A or 514I.

33 24 b. For purposes of this subsection, an association policy
33 25 under chapter 514E is not considered "qualifying existing
33 26 coverage" or "qualifying previous coverage".

33 27 Sec. 29. Section 514A.3B, subsection 1, Code 2009, is
33 28 amended to read as follows:

33 29 1. An insurer which accepts an individual for coverage
33 30 under an individual policy or contract of accident and health
33 31 insurance shall waive any time period applicable to a
33 32 preexisting condition exclusion or limitation period
33 33 requirement of the policy or contract with respect to
33 34 particular services in an individual health benefit plan for
33 35 the period of time the individual was previously covered by
34 1 qualifying previous coverage as defined in section 513C.3 that
34 2 provided benefits with respect to such services, provided that
34 3 the qualifying previous coverage was continuous to a date not
34 4 more than sixty-three days prior to the effective date of the
34 5 new policy or contract. ~~Any days of coverage provided to an~~

~~individual pursuant to chapter 249A or 514I, or Medicare~~
34 7 ~~coverage provided pursuant to Title XVIII of the federal~~
34 8 ~~Social Security Act, do not constitute qualifying previous~~
34 9 ~~coverage. Such days of ~~chapter 249A or 514I or Medicare~~~~
34 10 ~~coverage shall be counted as part of the maximum~~

34 11 ~~sixty-three-day grace period and shall not constitute a basis~~
34 12 ~~for the waiver of any preexisting condition exclusion or~~
34 13 ~~limitation period. Any days of coverage provided to an~~
34 14 ~~individual pursuant to chapter 249A or 514I constitute~~
34 15 ~~qualifying previous coverage.~~

34 16 Sec. 30. Section 514E.5, subsections 1 and 7, Code 2009,
34 17 are amended to read as follows:

34 18 1. The association, in consultation with the Iowa choice
34 19 health care coverage advisory council, shall develop a
34 20 comprehensive health care coverage plan to provide health care
34 21 coverage to all children without such coverage, that utilizes
34 22 and modifies existing public programs including the medical
34 23 assistance program, and hawk=i program, and hawk=i expansion
~~program,~~ and to provide access to private unsubsidized,
34 25 affordable, qualified health care coverage to children who are
34 26 not otherwise eligible for health care coverage through public
34 27 programs.

34 28 7. The association shall submit the comprehensive plan

34 29 required by this section to the governor and the general
34 30 assembly by December 15, 2008. The appropriations to cover
34 31 children under the medical assistance, ~~and hawk=i, and hawk=i~~
~~34 32 expansion programs as provided in this Act and to provide~~
34 33 related outreach for fiscal year 2009=2010 and fiscal year
34 34 2010=2011 are contingent upon enactment of a comprehensive
34 35 plan during the 2009 regular session of the Eighty=third
35 1 General Assembly that provides health care coverage for all
35 2 children in the state. Enactment of a comprehensive plan
35 3 shall include a determination of what the prospects are of
35 4 federal action which may impact the comprehensive plan and the
35 5 fiscal impact of the comprehensive plan on the state budget.

35 6 Sec. 31. Section 514I.1, subsection 4, Code 2009, is
35 7 amended to read as follows:

35 8 4. It is the intent of the general assembly that the
35 9 hawk=i program be an integral part of the continuum of health
35 10 insurance coverage and that the program be developed and
35 11 implemented in such a manner as to facilitate movement of
35 12 families between health insurance providers and to facilitate
35 13 the transition of families to private sector health insurance
35 14 coverage. ~~It is the intent of the general assembly in~~
~~35 15 developing such continuum of health insurance coverage and in~~
~~35 16 facilitating such transition, that beginning July 1, 2009, the~~
~~35 17 department implement the hawk=i expansion program.~~

35 18 Sec. 32. Section 514I.2, subsection 8, Code 2009, is
35 19 amended by striking the subsection.

35 20 Sec. 33. Section 514I.3, Code 2009, is amended by adding
35 21 the following new subsection:

35 22 NEW SUBSECTION. 6. Health care coverage provided under
35 23 this chapter in accordance with Title XXI of the federal
35 24 Social Security Act shall be recognized as prior creditable
35 25 coverage as defined in the federal Health Insurance
35 26 Portability and Accountability Act of 1996, Pub. L. No.
35 27 104=191, and as qualifying previous coverage as defined in
35 28 sections 514A.3B and 513C.3 for the purposes of portability to
35 29 private individual or group health insurance coverage. If
35 30 necessary to prove such prior creditable coverage or
35 31 qualifying previous coverage, the department shall issue
35 32 certificates of creditable coverage to the family of a
35 33 participating eligible child moving from coverage under this
35 34 chapter to private health care coverage.

35 35 Sec. 34. Section 514I.4, subsection 2, Code 2009, is
36 1 amended to read as follows:

36 2 2. a. The director, with the approval of the board, may
36 3 contract with participating insurers to provide dental=only
36 4 services.

36 5 ~~b. The director, with the approval of the board, may~~
~~36 6 contract with participating insurers to provide the~~
~~36 7 supplemental dental=only coverage to otherwise eligible~~
~~36 8 children who have private health care coverage as specified in~~
~~36 9 the federal Children's Health Insurance Program~~
~~36 10 Reauthorization Act of 2009, Pub. L. No. 111=3.~~

36 11 Sec. 35. Section 514I.4, subsection 5, paragraphs a and b,
36 12 Code 2009, are amended to read as follows:

36 13 a. Develop a joint program application form ~~not to exceed~~
~~36 14 two pages in length, which is consistent with the rules of the~~
~~36 15 board, which is easy to understand, complete, and concise, and~~
~~36 16 which, to the greatest extent possible, coordinates with the~~
~~36 17 supplemental forms, and the same application and renewal~~
~~36 18 verification process for both the hawk=i and medical~~
36 19 assistance ~~program programs.~~

36 20 b. (1) Establish the family cost sharing amounts for
~~36 21 children of families with incomes of one hundred fifty percent~~
~~36 22 or more but not exceeding two hundred percent of the federal~~
~~36 23 poverty level, of not less than ten dollars per individual and~~
~~36 24 twenty dollars per family, if not otherwise prohibited by~~
~~36 25 federal law, with the approval of the board.~~

36 26 (2) Establish for children of families with incomes
~~36 27 exceeding two hundred percent but not exceeding three hundred~~
~~36 28 percent of the federal poverty level, family cost=sharing~~
~~36 29 amounts, criteria for modification of the cost=sharing~~
~~36 30 amounts, and graduated premiums, in accordance with federal~~
~~36 31 law, with the approval of the board.~~

36 32 Sec. 36. Section 514I.5, subsection 7, paragraph 1, Code
36 33 2009, is amended to read as follows:

36 34 1. Develop options and recommendations to allow children
36 35 eligible for the hawk=i ~~or hawk=i expansion~~ program to
37 1 participate in qualified employer=sponsored health plans
37 2 through a premium assistance program. The options and
37 3 recommendations shall ensure reasonable alignment between the
37 4 benefits and costs of the hawk=i ~~and hawk=i expansion programs~~

37 5 program and the employer-sponsored health plans consistent
37 6 with federal law. The options and recommendations shall be
~~37 7 completed by January 1, 2009, and submitted to the governor~~
~~37 8 and the general assembly for consideration as part of the~~
~~37 9 hawk-i and hawk-i expansion programs. In addition, the board~~
37 10 shall implement the premium assistance program options
37 11 described under the federal Children's Health Insurance
37 12 Program Reauthorization Act of 2009, Pub. L. No. 111=3, for
37 13 the hawk=i program.

37 14 Sec. 37. Section 514I.5, subsection 8, paragraph e, Code
37 15 2009, is amended by adding the following new subparagraph:
37 16 NEW SUBPARAGRAPH. (15) Translation and interpreter
37 17 services as specified pursuant to the federal Children's
37 18 Health Insurance Program Reauthorization Act of 2009, Pub. L.
37 19 No. 111=3.

37 20 Sec. 38. Section 514I.5, subsection 8, paragraph g, Code
37 21 2009, is amended to read as follows:

37 22 g. Presumptive eligibility criteria for the program.
37 23 Beginning July 1, 2009, presumptive eligibility shall be
37 24 provided for eligible children.

37 25 Sec. 39. Section 514I.5, subsection 9, Code 2009, is
37 26 amended to read as follows:

37 27 9. a. The hawk=i board may provide approval to the
37 28 director to contract with participating insurers to provide
37 29 dental-only services. In determining whether to provide such
37 30 approval to the director, the board shall take into
37 31 consideration the impact on the overall program of single
37 32 source contracting for dental services.

37 33 b. The hawk=i board may provide approval to the director
37 34 to contract with participating insurers to provide the

37 35 supplemental dental-only coverage to otherwise eligible
38 1 children who have private health care coverage as specified in
38 2 the federal Children's Health Insurance Program

38 3 Reauthorization Act of 2009, Pub. L. No. 111=3.

38 4 Sec. 40. Section 514I.6, subsections 2 and 3, Code 2009,
38 5 are amended to read as follows:

38 6 2. Provide or reimburse accessible, quality medical or
38 7 dental services.

38 8 3. Require that any plan provided by the participating
38 9 insurer establishes and maintains a conflict management system
38 10 that includes methods for both preventing and resolving
38 11 disputes involving the health or dental care needs of eligible
38 12 children, and a process for resolution of such disputes.

38 13 Sec. 41. Section 514I.6, subsection 4, paragraph a, Code
38 14 2009, is amended to read as follows:

38 15 a. A list of providers of medical or dental services under
38 16 the plan.

38 17 Sec. 42. Section 514I.7, subsection 2, paragraph d, Code
38 18 2009, is amended to read as follows:

38 19 d. Monitor and assess the medical and dental care provided
38 20 through or by participating insurers as well as complaints and
38 21 grievances.

38 22 Sec. 43. Section 514I.8, subsection 2, paragraph c, Code
38 23 2009, is amended to read as follows:

38 24 c. Is a member of a family whose income does not exceed
38 25 two three hundred percent of the federal poverty level, as
38 26 defined in 42 U.S.C. } 9902(2), including any revision
38 27 required by such section, and in accordance with the federal

38 28 Children's Health Insurance Program Reauthorization Act of
38 29 2009, Pub. L. No. 111=3.

38 30 Sec. 44. Section 514I.10, Code 2009, is amended by adding
38 31 the following new subsection:

38 32 NEW SUBSECTION. 2A. Cost sharing for an eligible child
38 33 whose family income exceeds two hundred percent but does not
38 34 exceed three hundred percent of the federal poverty level may
38 35 include copayments and graduated premium amounts which do not
39 1 exceed the limitations of federal law.

39 2 Sec. 45. Section 514I.11, subsections 1 and 3, Code 2009,
39 3 are amended to read as follows:

39 4 1. A hawk=i trust fund is created in the state treasury
39 5 under the authority of the department of human services, in
39 6 which all appropriations and other revenues of the program and
~~39 7 the hawk-i expansion program~~ such as grants, contributions,
39 8 and participant payments shall be deposited and used for the
39 9 purposes of the program and the hawk-i expansion program. The
39 10 moneys in the fund shall not be considered revenue of the
39 11 state, but rather shall be funds of the program.

39 12 3. Moneys in the fund are appropriated to the department
39 13 and shall be used to offset any program and hawk-i expansion
~~39 14 program~~ costs.

39 15 Sec. 46. MEDICAL ASSISTANCE PROGRAM == PROGRAMMATIC AND

39 16 PROCEDURAL PROVISIONS. The department of human services shall
39 17 adopt rules pursuant to chapter 17A to provide for all of the
39 18 following:

39 19 1. To allow for the submission of one pay stub per
39 20 employer by an individual as verification of earned income for
39 21 the medical assistance program when it is indicative of future
39 22 income.

39 23 2. To allow for an averaging of three years of income for
39 24 self-employed families to establish eligibility for the
39 25 medical assistance program.

39 26 3. To extend the period for annual renewal by medical
39 27 assistance members by mailing the renewal form to the member
39 28 on the first day of the month prior to the month of renewal.

39 29 4. To provide for all of the following in accordance with
39 30 the requirements for qualification for the performance bonus
39 31 payments described under the federal Children's Health
39 32 Insurance Program Reauthorization Act of 2009, Pub. L. No.
39 33 111=3:

39 34 a. Utilization of joint applications and supplemental
39 35 forms, and the same application and renewal verification
40 1 processes for the medical assistance and hawk=i programs.

40 2 b. Implementation of administrative or paperless
40 3 verification at renewal for the medical assistance program.

40 4 c. Utilization of presumptive eligibility when determining
40 5 a child's eligibility for the medical assistance program.

40 6 d. Utilization of the express lane option, including
40 7 utilization of other public program databases to reach and
40 8 enroll children in the medical assistance program.

40 9 5. To provide translation and interpretation services
40 10 under the medical assistance program as specified pursuant to
40 11 the federal Children's Health Insurance Program
40 12 Reauthorization Act of 2009, Pub. L. No. 111=3.

40 13 Sec. 47. HAWK=I PROGRAM == PROGRAMMATIC AND PROCEDURAL
40 14 PROVISIONS. The hawk=i board, in consultation with the
40 15 department of human services, shall adopt rules pursuant to
40 16 chapter 17A to provide for all of the following:

40 17 1. To allow for the submission of one pay stub per
40 18 employer by an individual as verification of earned income for
40 19 the hawk=i program when it is indicative of future income.

40 20 2. To allow for an averaging of three years of income for
40 21 self-employed families to establish eligibility for the hawk=i
40 22 program.

40 23 3. To provide for all of the following in accordance with
40 24 the requirements for qualification for the performance bonus
40 25 payments described under the federal Children's Health
40 26 Insurance Program Reauthorization Act of 2009, Pub. L. No.
40 27 111=3:

40 28 a. Utilization of joint applications and supplemental
40 29 forms, and the same application and renewal verification
40 30 processes for the hawk=i and medical assistance programs.

40 31 b. Implementation of administrative or paperless
40 32 verification at renewal for the hawk=i program.

40 33 c. Utilization of presumptive eligibility when determining
40 34 a child's eligibility for the hawk=i program.

40 35 d. Utilization of the express lane option, including
41 1 utilization of other public program databases to reach and
41 2 enroll children in the hawk=i program.

41 3 Sec. 48. DEMONSTRATION GRANTS == CHIPRA. The department
41 4 of human services in cooperation with the department of public
41 5 health and other appropriate agencies, shall apply for grants
41 6 available under the Children's Health Insurance Program
41 7 Reauthorization Act of 2009, Pub. L. No. 111=3, to promote
41 8 outreach activities and quality child health outcomes under
41 9 the medical assistance and hawk=i programs.

41 10 Sec. 49. Section 514I.12, Code 2009, is repealed.

41 11 Sec. 50. EFFECTIVE DATE. The section of this division of
41 12 this Act amending section 422.12M, takes effect July 1, 2010.

41 13 DIVISION IV

41 14 VOLUNTEER HEALTH CARE PROVIDERS

41 15 Sec. 51. Section 135.24, Code 2009, is amended to read as
41 16 follows:

41 17 135.24 VOLUNTEER HEALTH CARE PROVIDER PROGRAM ESTABLISHED
41 18 == IMMUNITY FROM CIVIL LIABILITY.

41 19 1. The director shall establish within the department a
41 20 program to provide to eligible hospitals, clinics, free
41 21 clinics, field dental clinics, health care provider offices,
41 22 or other health care facilities, health care referral
41 23 programs, or charitable organizations, free medical, dental,
41 24 chiropractic, pharmaceutical, nursing, optometric,
41 25 psychological, social work, behavioral science, podiatric,
41 26 physical therapy, occupational therapy, respiratory therapy,

41 27 and emergency medical care services given on a voluntary basis
41 28 by health care providers. A participating health care
41 29 provider shall register with the department and obtain from
41 30 the department a list of eligible, participating hospitals,
41 31 clinics, free clinics, field dental clinics, health care
41 32 provider offices, or other health care facilities, health care
41 33 referral programs, or charitable organizations.

41 34 2. The department, in consultation with the department of
41 35 human services, shall adopt rules to implement the volunteer
42 1 health care provider program which shall include the
42 2 following:

42 3 a. Procedures for registration of health care providers
42 4 deemed qualified by the board of medicine, the board of
42 5 physician assistants, the dental board, the board of nursing,
42 6 the board of chiropractic, the board of psychology, the board
42 7 of social work, the board of behavioral science, the board of
42 8 pharmacy, the board of optometry, the board of podiatry, the
42 9 board of physical and occupational therapy, the board of
42 10 respiratory care, and the Iowa department of public health, as
42 11 applicable.

42 12 b. Procedures for registration of free clinics, ~~and~~ field
42 13 dental clinics, and health care provider offices.

42 14 c. Criteria for and identification of hospitals, clinics,
42 15 free clinics, field dental clinics, health care provider
42 16 offices, or other health care facilities, health care referral
42 17 programs, or charitable organizations, eligible to participate
42 18 in the provision of free medical, dental, chiropractic,
42 19 pharmaceutical, nursing, optometric, psychological, social
42 20 work, behavioral science, podiatric, physical therapy,
42 21 occupational therapy, respiratory therapy, or emergency
42 22 medical care services through the volunteer health care
42 23 provider program. A free clinic, a field dental clinic, a
42 24 health care provider office, a health care facility, a health
42 25 care referral program, a charitable organization, or a health
42 26 care provider participating in the program shall not bill or
42 27 charge a patient for any health care provider service provided
42 28 under the volunteer health care provider program.

42 29 d. Identification of the services to be provided under the
42 30 program. The services provided may include, but shall not be
42 31 limited to, obstetrical and gynecological medical services,
42 32 psychiatric services provided by a physician licensed under
42 33 chapter 148, dental services provided under chapter 153, or
42 34 other services provided under chapter 147A, 148A, 148B, 148C,
42 35 149, 151, 152, 152B, 152E, 154, 154B, 154C, 154D, 154F, or
43 1 155A.

43 2 3. A health care provider providing free care under this
43 3 section shall be considered an employee of the state under
43 4 chapter 669, shall be afforded protection as an employee of
43 5 the state under section 669.21, and shall not be subject to
43 6 payment of claims arising out of the free care provided under
43 7 this section through the health care provider's own
43 8 professional liability insurance coverage, provided that the
43 9 health care provider has done all of the following:

43 10 a. Registered with the department pursuant to subsection
43 11 1.

43 12 b. Provided medical, dental, chiropractic, pharmaceutical,
43 13 nursing, optometric, psychological, social work, behavioral
43 14 science, podiatric, physical therapy, occupational therapy,
43 15 respiratory therapy, or emergency medical care services
43 16 through a hospital, clinic, free clinic, field dental clinic,
43 17 health care provider office, or other health care facility,
43 18 health care referral program, or charitable organization
43 19 listed as eligible and participating by the department
43 20 pursuant to subsection 1.

43 21 4. A free clinic providing free care under this section
43 22 shall be considered a state agency solely for the purposes of
43 23 this section and chapter 669 and shall be afforded protection
43 24 under chapter 669 as a state agency for all claims arising
43 25 from the provision of free care by a health care provider
43 26 registered under subsection 3 who is providing services at the
43 27 free clinic in accordance with this section or from the
43 28 provision of free care by a health care provider who is
43 29 covered by adequate medical malpractice insurance as
43 30 determined by the department, if the free clinic has
43 31 registered with the department pursuant to subsection 1.

43 32 5. A field dental clinic providing free care under this
43 33 section shall be considered a state agency solely for the
43 34 purposes of this section and chapter 669 and shall be afforded
43 35 protection under chapter 669 as a state agency for all claims
44 1 arising from the provision of free care by a health care
44 2 provider registered under subsection 3 who is providing

44 3 services at the field dental clinic in accordance with this
44 4 section or from the provision of free care by a health care
44 5 provider who is covered by adequate medical malpractice
44 6 insurance, as determined by the department, if the field
44 7 dental clinic has registered with the department pursuant to
44 8 subsection 1.

44 9 5A. A health care provider office providing free care
44 10 under this section shall be considered a state agency solely
44 11 for the purposes of this section and chapter 669 and shall be
44 12 afforded protection under chapter 669 as a state agency for
44 13 all claims arising from the provision of free care by a health
44 14 care provider registered under subsection 3 who is providing
44 15 services at the health care provider office in accordance with
44 16 this section or from the provision of free care by a health
44 17 care provider who is covered by adequate medical malpractice
44 18 insurance, as determined by the department, if the health care
44 19 provider office has registered with the department pursuant to
44 20 subsection 1.

44 21 6. For the purposes of this section:

44 22 a. "Charitable organization" means a charitable
44 23 organization within the meaning of section 501(c)(3) of the
44 24 Internal Revenue Code.

44 25 b. "Field dental clinic" means a dental clinic temporarily
44 26 or periodically erected at a location utilizing mobile dental
44 27 equipment, instruments, or supplies, as necessary, to provide
44 28 dental services.

44 29 c. "Free clinic" means a facility, other than a hospital
44 30 or health care provider's office which is exempt from taxation
44 31 under section 501(c)(3) of the Internal Revenue Code and which
44 32 has as its sole purpose the provision of health care services
44 33 without charge to individuals who are otherwise unable to pay
44 34 for the services.

44 35 d. "Health care provider" means a physician licensed under
45 1 chapter 148, a chiropractor licensed under chapter 151, a
45 2 physical therapist licensed pursuant to chapter 148A, an
45 3 occupational therapist licensed pursuant to chapter 148B, a
45 4 podiatrist licensed pursuant to chapter 149, a physician
45 5 assistant licensed and practicing under a supervising
45 6 physician pursuant to chapter 148C, a licensed practical
45 7 nurse, a registered nurse, or an advanced registered nurse
45 8 practitioner licensed pursuant to chapter 152 or 152E, a
45 9 respiratory therapist licensed pursuant to chapter 152B, a
45 10 dentist, dental hygienist, or dental assistant registered or
45 11 licensed to practice under chapter 153, an optometrist
45 12 licensed pursuant to chapter 154, a psychologist licensed
45 13 pursuant to chapter 154B, a social worker licensed pursuant to
45 14 chapter 154C, a mental health counselor or a marital and
45 15 family therapist licensed pursuant to chapter 154D,* a
45 16 pharmacist licensed pursuant to chapter 155A, or an emergency
45 17 medical care provider certified pursuant to chapter 147A.

45 18 e. "Health care provider office" means the private office
45 19 or clinic of an individual health care provider or group of
45 20 health care providers but does not include a field dental
45 21 clinic, a free clinic, or a hospital.

45 22 DIVISION V

45 23 HEALTH CARE WORKFORCE SUPPORT INITIATIVE

45 24 Sec. 52. Section 135.11, Code 2009, is amended by adding
45 25 the following new subsection:

45 26 NEW SUBSECTION. 32. Administer the portion of the
45 27 workforce shortage initiative established in section 261.128
45 28 relating to the medical residency training state matching
45 29 grants program.

45 30 Sec. 53. Section 135.153, subsection 2, Code 2009, is
45 31 amended to read as follows:

45 32 2. a. The network shall form a governing group which
45 33 includes two individuals each representing community health
45 34 centers, rural health clinics, free clinics, maternal and
45 35 child health centers, the expansion population provider
46 1 network as described in chapter 249J, local boards of health
46 2 that provide direct services, the state board of health, Iowa
46 3 family planning network agencies, child health specialty
46 4 clinics, and other safety net providers.

46 5 b. The governing group shall administer the portion of the
46 6 workforce shortage initiative established in section 261.128
46 7 relating to the safety net provider recruitment and retention
46 8 initiatives program.

46 9 Sec. 54. Section 261.2, Code 2009, is amended by adding
46 10 the following new subsection:

46 11 NEW SUBSECTION. 10. Administer the portions of the health
46 12 care workforce support initiative established in section
46 13 261.128 relating to the health care professional incentive

46 14 payment program and the nursing workforce shortage initiative.

46 15 Sec. 55. Section 261.23, subsection 1, Code 2009, is
46 16 amended to read as follows:

46 17 1. A registered nurse and nurse educator loan forgiveness
46 18 program is established to be administered by the commission.
46 19 The program shall consist of loan forgiveness for eligible
46 20 federally guaranteed loans for registered nurses and nurse
46 21 educators who practice or teach in this state. For purposes
46 22 of this section, unless the context otherwise requires, "nurse
46 23 educator" means a registered nurse who holds a master's degree
46 24 or doctorate degree and is employed as a faculty member who
46 25 teaches nursing as provided in 655 IAC 2.6(152) at a community
46 26 college, an accredited private institution, or an institution
46 27 of higher education governed by the state board of regents.

46 28 Sec. 56. Section 261.23, subsection 2, paragraph c, Code
46 29 2009, is amended to read as follows:

46 30 c. Complete and return, on a form approved by the
46 31 commission, an affidavit of practice verifying that the
46 32 applicant is a registered nurse practicing in this state or a
46 33 nurse educator teaching at a community college, an accredited
46 34 private institution, or an institution of higher learning
46 35 governed by the state board of regents.

47 1 Sec. 57. NEW SECTION. 261.128 HEALTH CARE WORKFORCE
47 2 SUPPORT INITIATIVE == WORKFORCE SHORTAGE FUND.

47 3 1. HEALTH CARE WORKFORCE SHORTAGE FUND == ACCOUNTS.

47 4 a. A health care workforce shortage fund is created in the
47 5 state treasury as a separate fund under the control of the
47 6 commission, the department of public health, the governing
47 7 group of the Iowa collaborative safety net provider network as
47 8 described in section 135.153, or the state entity identified
47 9 for receipt of the federal funds by the federal government
47 10 entity through which the federal funding is available for a
47 11 specified health care workforce shortage initiative, as
47 12 specified in this subsection. The fund and the accounts
47 13 within the fund shall consist of moneys appropriated from the
47 14 general fund of the state for the healthcare workforce support
47 15 initiative; moneys received from the federal government for
47 16 the purposes of addressing the health care workforce shortage;
47 17 contributions, grants, and other moneys from communities and
47 18 health care employers; and moneys from any other public or
47 19 private source available. The commission, the department of
47 20 public health, the governing group of the Iowa collaborative
47 21 safety net provider network as described in section 135.153,
47 22 or the state entity identified for receipt of the federal
47 23 funds by the federal government entity through which the
47 24 federal funding is available for a specified health care
47 25 workforce shortage initiative may receive contributions,
47 26 grants, and in-kind contributions to support the purposes of
47 27 the fund and the accounts within the fund.

47 28 b. The fund and the accounts within the fund shall be
47 29 separate from the general fund of the state and shall not be
47 30 considered part of the general fund of the state. The moneys
47 31 in the fund and the accounts within the fund shall not be
47 32 considered revenue of the state, but rather shall be moneys of
47 33 the fund or the accounts. The moneys in the fund and the
47 34 accounts within the fund are not subject to section 8.33 and
47 35 shall not be transferred, used, obligated, appropriated, or
48 1 otherwise encumbered, except to provide for the purposes of
48 2 this section. Notwithstanding section 12C.7, subsection 2,
48 3 interest or earnings on moneys deposited in the fund shall be
48 4 credited to the fund and the accounts within the fund.

48 5 c. The fund shall consist of the following accounts:

48 6 (1) The medical residency training account. The medical
48 7 residency training account shall be under the control of the
48 8 department of public health and the moneys in the account
48 9 shall be used for the purposes of the medical residency
48 10 training state matching grants program as specified in this
48 11 section. Moneys in the account shall consist of moneys
48 12 received by the fund or the account and specifically dedicated
48 13 to the medical residency training account and for the purposes
48 14 of such account.

48 15 (2) The health care professional and nurse workforce
48 16 shortage initiative account. The health care professional and
48 17 nurse workforce shortage initiative account shall be under the
48 18 control of the commission and the moneys in the account shall
48 19 be used for the purposes of the health care professional
48 20 incentive payment program and the nurse workforce shortage
48 21 initiative as specified in this section. Moneys in the
48 22 account shall consist of moneys received by the fund or the
48 23 account and specifically dedicated to the health care
48 24 professional and nurse workforce shortage initiative account

48 25 and for the purposes of the account.
48 26 (3) The safety net provider network workforce shortage
48 27 account. The safety net provider network workforce shortage
48 28 account shall be under the control of the governing group of
48 29 the Iowa collaborative safety net provider network and the
48 30 moneys in the account shall be used for the purposes of the
48 31 safety net provider recruitment and retention initiatives
48 32 program as specified in this section. Moneys in the account
48 33 shall consist of moneys received by the fund or the account
48 34 and specifically dedicated to the safety net provider network
48 35 workforce shortage account and for the purposes of the
49 1 account.

49 2 (4) The health care workforce shortage national
49 3 initiatives account. The health care workforce shortage
49 4 national initiatives account shall be under the control of the
49 5 state entity identified for receipt of the federal funds by
49 6 the federal government entity through which the federal
49 7 funding is available for a specified health care workforce
49 8 shortage initiative. Moneys in the account shall consist of
49 9 moneys received by the fund or the account and specifically
49 10 dedicated to the health care workforce shortage national
49 11 initiatives account and for a specified health care workforce
49 12 shortage initiative.

49 13 d. (1) Moneys in the fund and the accounts in the fund
49 14 shall only be appropriated to support the medical residency
49 15 training state matching grants program, the health care
49 16 professional incentive payment program, the nurse educator
49 17 incentive payment and nursing faculty fellowship programs, the
49 18 safety net recruitment and retention initiatives program, for
49 19 national health care workforce shortage initiatives, and to
49 20 provide funding for state health care workforce shortage
49 21 programs as provided in this section.

49 22 (2) For the purposes of this section, in addition to the
49 23 programs otherwise specified in this section to receive
49 24 funding, state health care workforce shortage programs that
49 25 may receive funding from the fund or the accounts within the
49 26 fund in order to draw down the maximum amount of federal
49 27 funding available are the primary care recruitment and
49 28 retention endeavor (PRIMECARRE), the Iowa affiliate of the
49 29 national rural recruitment and retention network, the primary
49 30 care office shortage designation program, the state office of
49 31 rural health, and the Iowa health workforce center,
49 32 administered through the bureau of health care access of the
49 33 department of public health; the area health education centers
49 34 programs at Des Moines university == osteopathic medical
49 35 center and the university of Iowa; the Iowa collaborative
50 1 safety net provider network established pursuant to section
50 2 135.153; and any entity identified by the federal government
50 3 entity through which federal funding for a specified health
50 4 care workforce shortage initiative is received.

50 5 (3) State appropriations from the fund shall be made in
50 6 equal amounts to each of the accounts within the fund. Any
50 7 federal funding received for the purposes of addressing state
50 8 health care workforce shortages shall, unless otherwise
50 9 restricted by federal law or regulation, be allocated equally
50 10 between the workforce represented by the Iowa safety net
50 11 provider network and other eligible health care providers in
50 12 the state.

50 13 e. No more than five percent of the moneys in any of the
50 14 accounts within the fund, not to exceed one hundred thousand
50 15 dollars in each account, shall be used for administrative
50 16 purposes, unless otherwise provided by the source of the
50 17 funds.

50 18 2. MEDICAL RESIDENCY TRAINING STATE MATCHING GRANTS 50 19 PROGRAM.

50 20 a. The department of public health shall establish a
50 21 medical residency training state matching grants program to
50 22 provide matching state funding to sponsors of accredited
50 23 graduate medical education residency programs in this state to
50 24 establish, expand, or support medical residency training
50 25 programs. For the purposes of this section, unless the
50 26 context otherwise requires, "accredited" means a graduate
50 27 medical education program approved by the accreditation
50 28 council for graduate medical education. The grant funds may
50 29 be used to support medical residency programs through any of
50 30 the following:

50 31 (1) The establishment of new or alternative campus
50 32 accredited medical residency training programs. For the
50 33 purposes of this subparagraph, "new or alternative campus
50 34 accredited medical residency training program" means a program
50 35 that is accredited by a recognized entity approved for such

51 1 purpose by the accreditation council for graduate medical
51 2 education with the exception that a new medical residency
51 3 training program that, by reason of an insufficient period of
51 4 operation is not eligible for accreditation on or before the
51 5 date of submission of an application for a grant, may be
51 6 deemed accredited if the accreditation council for graduate
51 7 medical education finds, after consultation with the
51 8 appropriate accreditation entity, that there is reasonable
51 9 assurance that the program will meet the accreditation
51 10 standards of the entity prior to the date of graduation of the
51 11 initial class in the program.

51 12 (2) The provision of new residency positions within
51 13 existing accredited medical residency or fellowship training
51 14 programs.

51 15 (3) The funding of residency positions which are in excess
51 16 of the federal residency cap. For the purposes of this
51 17 subparagraph, "in excess of the federal residency cap" means a
51 18 residency position for which no federal Medicare funding is
51 19 available because the residency position is a position beyond
51 20 the cap for residency positions established by the federal
51 21 Balanced Budget Act of 1997, Pub. L. No. 105-33.

51 22 b. The department of public health shall adopt rules
51 23 pursuant to chapter 17A to provide for all of the following:

51 24 (1) Eligibility requirements for and qualifications of a
51 25 sponsor of an accredited graduate medical education residency
51 26 program to receive a grant. The requirements and
51 27 qualifications shall include but are not limited to all of the
51 28 following:

51 29 (a) Only a sponsor that establishes a dedicated fund to
51 30 support a residency program that meets the specifications of
51 31 this subsection shall be eligible to receive a matching grant.

51 32 (b) A sponsor shall demonstrate through documented
51 33 financial information as prescribed by rule of the department
51 34 of public health, that funds have been reserved by the sponsor
51 35 in the amount required to provide matching funds for each
52 1 residency proposed in the request for state matching funds.

52 2 (c) A sponsor shall demonstrate through objective evidence
52 3 as prescribed by rule of the department of public health, a
52 4 need for such residency program in the state.

52 5 (2) The application process for the grant.

52 6 (3) Criteria for preference in awarding of the grants,
52 7 including preference in the residency specialty.

52 8 (4) Determination of the amount of a grant. The total
52 9 amount of a grant awarded to a sponsor shall be limited to no
52 10 more than twenty-five percent of the amount that the sponsor
52 11 has demonstrated through documented financial information has
52 12 been reserved by the sponsor for each residency sponsored for
52 13 the purpose of the residency program.

52 14 (5) The maximum award of grant funds to a particular
52 15 individual sponsor per year. An individual sponsor shall not
52 16 receive more than twenty-five percent of the state matching
52 17 funds available each year to support the program.

52 18 (6) Use of the funds awarded. Funds may be used to pay
52 19 the costs of establishing, expanding, or supporting an
52 20 accredited graduate medical education program as specified in
52 21 this section, including but not limited to the costs
52 22 associated with residency stipends and physician faculty
52 23 stipends.

52 24 3. HEALTH CARE PROFESSIONAL INCENTIVE PAYMENT PROGRAM.

52 25 a. The commission shall establish a health care
52 26 professional incentive payment program to recruit and retain
52 27 health care professionals in this state.

52 28 b. The commission shall administer the incentive payment
52 29 program with the assistance of Des Moines university ==
52 30 osteopathic medical center. From funds appropriated from the
52 31 health care professional and nurse workforce shortage
52 32 initiative account of the health care workforce shortage fund
52 33 for the purposes of the program, the commission shall pay a
52 34 fee to Des Moines university == osteopathic medical center for
52 35 the administration of the program.

53 1 c. The commission, with the assistance of Des Moines
53 2 university == osteopathic medical center, shall adopt rules
53 3 pursuant to chapter 17A, relating to the establishment and
53 4 administration of the health care professional incentive
53 5 payment program. The rules adopted shall address all of the
53 6 following:

53 7 (1) Eligibility and qualification requirements for a
53 8 health care professional, a community, and a health care
53 9 employer to participate in the incentive payment program. Any
53 10 community in the state and all health care specialties shall
53 11 be considered for participation. However, health care

53 12 providers located in and communities that are designated as
53 13 medically underserved areas or populations or that are
53 14 designated as health professional shortage areas by the health
53 15 resources and services administration of the United States
53 16 department of health and human services shall have first
53 17 priority in the awarding of incentive payments.

53 18 (a) To be eligible, a health care professional at a
53 19 minimum must not have any unserved obligations to a federal,
53 20 state, or local government or other entity that would prevent
53 21 compliance with obligations under the loan; must have a
53 22 current and unrestricted license to practice the
53 23 professional's respective profession; and must be able to
53 24 begin full-time clinical practice upon signing an agreement
53 25 for an incentive payment.

53 26 (b) To be eligible, a community must provide a clinical
53 27 setting for full-time practice of a health care professional
53 28 and must provide a fifty thousand dollar matching contribution
53 29 for a physician and a fifteen thousand dollar matching
53 30 contribution for any other health care professional to receive
53 31 an equal amount of state matching funds.

53 32 (c) To be eligible, a health care employer must provide a
53 33 clinical setting for a full-time practice of a health care
53 34 professional and must provide a fifty thousand dollar matching
53 35 contribution for a physician and a fifteen thousand dollar
54 1 matching contribution for any other health care professional
54 2 to receive an equal amount of state matching funds.

54 3 (2) The process for awarding incentive payments. The
54 4 commission shall receive recommendations from the department
54 5 of public health regarding selection of incentive payment
54 6 recipients. The process shall require each recipient to enter
54 7 into an agreement with the commission that specifies the
54 8 obligations of the recipient and the commission prior to
54 9 receiving the incentive payment.

54 10 (3) Public awareness regarding the program including
54 11 notification of potential health care professionals,
54 12 communities, and health care employers about the program and
54 13 dissemination of applications to appropriate entities.

54 14 (4) Measures regarding all of the following:

54 15 (a) The amount of the incentive payment and the specifics
54 16 of obligated service for an incentive payment recipient. An
54 17 incentive payment recipient shall agree to provide service in
54 18 full-time clinical practice for a minimum of four years. If
54 19 an incentive payment recipient is sponsored by a community or
54 20 health care entity partner, the obligated service shall be
54 21 provided in the sponsoring community or health care entity
54 22 location. An incentive payment recipient sponsored by a
54 23 health care employer shall agree to provide health care
54 24 services as specified in an employment agreement with the
54 25 sponsoring health care entity.

54 26 (b) Determination of the conditions of the incentive
54 27 payment applicable to an incentive payment recipient. At the
54 28 time of approval for participation in the program, an
54 29 incentive payment recipient shall be required to submit proof
54 30 of indebtedness incurred as the result of obtaining loans to
54 31 pay for educational costs resulting in a degree in health
54 32 sciences. For the purposes of this subparagraph division,
54 33 "indebtedness" means debt incurred from obtaining a government
54 34 or commercial loan for actual costs paid for tuition,
54 35 reasonable education expenses, and reasonable living expenses
55 1 related to the graduate, undergraduate, or associate education
55 2 of a health care professional.

55 3 (c) Enforcement of the state's rights under an incentive
55 4 payment agreement, including the commencement of any court
55 5 action. A recipient who fails to fulfill the requirements of
55 6 the incentive payment agreement is subject to repayment of the
55 7 incentive payment in an amount equal to the amount of the
55 8 incentive payment. A recipient who fails to meet the
55 9 requirements of the incentive payment agreement may also be
55 10 subject to repayment of moneys advanced by a community or
55 11 health care employer partner as provided in any agreement with
55 12 the partner.

55 13 (d) A process for monitoring compliance with eligibility
55 14 requirements, obligated service provisions, and use of funds
55 15 by recipients to verify eligibility of recipients and to
55 16 ensure that state, federal, and other matching funds are used
55 17 in accordance with program requirements.

55 18 (e) The use of the funds received. Any portion of the
55 19 incentive payment that is attributable to federal funds shall
55 20 be used as required by the federal entity providing the funds.
55 21 Any portion of the incentive payment that is attributable to
55 22 state funds shall first be used toward payment of any

55 23 outstanding loan indebtedness of the recipient. The remaining
55 24 portion of the incentive payment shall be used as specified in
55 25 the incentive payment agreement.

55 26 d. A recipient is responsible for reporting on federal
55 27 income tax forms any amount received through the program, to
55 28 the extent required by federal law. Incentive payments
55 29 received through the program by a recipient in compliance with
55 30 the requirements of the incentive payment program are exempt
55 31 from state income taxation.

55 32 5. NURSING WORKFORCE SHORTAGE INITIATIVE.

55 33 a. NURSE EDUCATOR INCENTIVE PAYMENT PROGRAM.

55 34 (1) The commission shall establish a nurse educator
55 35 incentive payment program. For the purposes of this
56 1 paragraph, "nurse educator" means a registered nurse who holds
56 2 a master's degree or doctorate degree and is employed as a
56 3 faculty member who teaches nursing in a nursing education
56 4 program as provided in 655 IAC 2.6 at a community college, an
56 5 accredited private institution, or an institution of higher
56 6 education governed by the state board of regents.

56 7 (2) The program shall consist of incentive payments to
56 8 recruit and retain nurse educators. The program shall provide
56 9 for incentive payments of up to twenty thousand dollars for a
56 10 nurse educator who remains teaching in a qualified teaching
56 11 position for a period of not less than four consecutive
56 12 academic years.

56 13 (3) The nurse educator and the commission shall enter into
56 14 an agreement specifying the obligations of the nurse educator
56 15 and the commission. If the nurse educator leaves the
56 16 qualifying teaching position prior to teaching for four
56 17 consecutive academic years, the nurse educator shall be liable
56 18 to repay the incentive payment amount to the state, plus
56 19 interest as specified by rule. However, if the nurse educator
56 20 leaves the qualifying teaching position involuntarily, the
56 21 nurse educator shall be liable to repay only a pro rata amount
56 22 of the incentive payment based on incompleting years of
56 23 service.

56 24 (4) The commission, in consultation with the advisory
56 25 council, shall adopt rules pursuant to chapter 17A relating to
56 26 the establishment and administration of the nurse educator
56 27 incentive payment program. The rules shall include provisions
56 28 specifying what constitutes a qualifying teaching position.

56 29 b. NURSING FACULTY FELLOWSHIP PROGRAM.

56 30 (1) The commission shall establish a nursing faculty
56 31 fellowship program to provide funds to nursing schools in the
56 32 state, including but not limited to nursing schools located at
56 33 community colleges, for fellowships for individuals employed
56 34 in qualifying positions on the nursing faculty. The program
56 35 shall be designed to assist nursing schools in filling
57 1 vacancies in qualifying positions throughout the state.

57 2 (2) The commission, in consultation with the department of
57 3 public health and in cooperation with nursing schools
57 4 throughout the state, shall develop a distribution formula
57 5 which shall provide that no more than thirty percent of the
57 6 available moneys are awarded to a single nursing school.
57 7 Additionally, the program shall limit funding for a qualifying
57 8 position in a nursing school to no more than ten thousand
57 9 dollars per year for up to three years.

57 10 (3) The commission, in consultation with the department of
57 11 public health, shall adopt rules pursuant to chapter 17A to
57 12 administer the program. The rules shall include provisions
57 13 specifying what constitutes a qualifying position at a nursing
57 14 school.

57 15 (4) In determining eligibility for a fellowship, the
57 16 commission shall consider all of the following:

57 17 (a) The length of time a qualifying position has gone
57 18 unfilled at a nursing school.

57 19 (b) Documented recruiting efforts by a nursing school.

57 20 (c) The geographic location of a nursing school.

57 21 (d) The type of nursing program offered at the nursing
57 22 school, including associate, bachelor's, master's, or doctoral
57 23 degrees in nursing, and the need for the specific nursing
57 24 program in the state.

57 25 6. SAFETY NET PROVIDER RECRUITMENT AND RETENTION

57 26 INITIATIVES PROGRAM. The Iowa collaborative safety net
57 27 provider network governing group as described in section
57 28 135.153, shall establish a safety net provider incentive
57 29 payment program to administer recruitment and retention
57 30 initiatives that may include but are not limited to loan
57 31 repayment and loan forgiveness programs to address the health
57 32 care workforce shortages of safety net providers. The
57 33 department of public health, in cooperation with the Iowa

57 34 collaborative safety net provider network shall adopt rules
57 35 pursuant to chapter 17A for the implementation and
58 1 administration of such initiatives.
58 2 7. ANNUAL REPORT. The commission shall submit an annual
58 3 report to the governor and the general assembly regarding the
58 4 status of the health care workforce support initiative,
58 5 including the balance remaining in and appropriations from the
58 6 health care workforce shortage fund.

58 7 Sec. 58. HEALTH CARE WORKFORCE INITIATIVES == FEDERAL
58 8 FUNDING. The department of public health shall work with the
58 9 department of workforce development and health care
58 10 stakeholders to apply for federal moneys allocated in the
58 11 federal American Recovery and Reinvestment Act of 2009 for
58 12 health care workforce initiatives that are available through a
58 13 competitive grant process administered by the health resources
58 14 and services administration of the United States department of
58 15 health and human services or the United States department of
58 16 health and human services. Any federal moneys received shall
58 17 be deposited in the health care workforce shortage fund
58 18 created in section 261.128 of this Act and shall be used for
58 19 the purposes specified for the fund and for the purposes
58 20 specified in the federal American Recovery and Reinvestment
58 21 Act of 2009.

58 22 Sec. 59. Sections 261.19 and 261.19B, Code 2009, are
58 23 repealed.

58 24 Sec. 60. CODE EDITOR DIRECTIVE. The Code editor shall
58 25 create a new division in chapter 261 codifying section
58 26 261.128, as enacted in this Act, as the health care workforce
58 27 support initiative.

58 28
58 29 DIVISION VI
58 30 PHARMACEUTICAL=RELATED INITIATIVES

58 31 MEDICATION THERAPY MANAGEMENT
58 32 Sec. 61. MEDICATION THERAPY MANAGEMENT == FINDINGS,
58 33 DIRECTIVE, REPORT.

58 34 1. The general assembly finds all of the following:

58 35 a. The utilization and reimbursement of pharmaceutical
59 1 case management services under the medical assistance program
59 2 has resulted in the successful management of chronic disease
59 3 states of medical assistance program recipients in a
59 4 cost=effective manner.

59 5 b. The utilization of pharmaceutical case management or
59 6 medication therapy management is consistent with the concept
59 7 of a medical home, as defined in section 135.157.

59 8 c. The success and cost=effectiveness of medication
59 9 therapy management in public programs such as the medical
59 10 assistance and federal Medicare programs could also be
59 11 realized through private health care coverage and should be a
59 12 covered benefit under individual and group health insurance
59 13 policies.

59 14 2. Based upon these findings, the general assembly directs
59 15 all health insurance plans in the state subject to regulation
59 16 by the commissioner of insurance to examine the feasibility
59 17 and efficacy of including medication therapy management as a
59 18 covered benefit under individual and group health insurance
59 19 policies.

59 20 a. If the health insurance plan determines the inclusion
59 21 of medication therapy management as a covered benefit to be
59 22 feasible and efficacious, the general assembly encourages the
59 23 plan to provide such coverage by January 1, 2010.

59 24 b. If the health insurance plan determines that inclusion
59 25 of medication therapy management as a covered benefit is not
59 26 feasible and efficacious, and does not provide coverage of the
59 27 health insurance plan by January 1, 2010, the health care plan
59 28 shall submit, to the chairpersons of the committees on human
59 29 resources of the senate and house of representatives by
59 30 January 1, 2010, a written report detailing the health
59 31 insurance plan's examination and analysis of the issue and any
59 32 reasons and supporting data for not including medication
59 33 therapy management as a covered benefit.

59 34 3. For the purposes of this section, "medication therapy
59 35 management" means pharmaceutical case management services as
60 1 provided under the medical assistance program in accordance
60 2 with 441 IAC 78.47.

60 3 EVIDENCE=BASED PRESCRIPTION DRUG EDUCATION PROGRAM

60 4 Sec. 62. NEW SECTION. 155B.1 DEFINITIONS.

60 5 As used in this chapter, unless the context otherwise
60 6 requires:

60 7 1. "Board" means the board of pharmacy.

60 8 2. "Department" means the department of public health.

60 9 3. "Prescription drug" means prescription drug as defined
60 9 in section 155A.3.

60 10 Sec. 63. NEW SECTION. 155B.2 EVIDENCE=BASED PRESCRIPTION
60 11 DRUG EDUCATION PROGRAM.

60 12 1. The board shall establish and administer an
60 13 evidence=based prescription drug education program designed to
60 14 provide health care professionals who are licensed to
60 15 prescribe or dispense prescription drugs with information and
60 16 education regarding the therapeutic and cost=effective
60 17 utilization of prescription drugs.

60 18 2. a. In establishing and administering the program, the
60 19 board shall request input and collaboration from physicians,
60 20 pharmacists, private insurers, hospitals, pharmacy benefits
60 21 managers, the medical assistance drug utilization review
60 22 commission, medical and pharmacy schools, and other entities
60 23 providing evidence=based education to health care
60 24 professionals that are licensed to prescribe or dispense
60 25 prescription drugs. To the greatest extent possible, the
60 26 information regarding the therapeutic and cost=effective
60 27 utilization of prescription drugs shall be gender, race,
60 28 ethnicity, and age specific.

60 29 b. The board may contract with an Iowa=based college of
60 30 pharmacy to provide technical and clinical support to the
60 31 board in establishing and administering the program.

60 32 3. The department may establish and collect fees from
60 33 private payors for participation in the program. The
60 34 department may seek funding from nongovernmental health
60 35 foundations or other nonprofit charitable foundations to
61 1 establish and administer the program.

61 2 GIFTS TO HEALTH CARE PRACTITIONERS

61 3 Sec. 64. NEW SECTION. 155C.1 PURPOSES.

61 4 The purposes of this chapter are to improve the public
61 5 health and the quality of prescribing and medical decision
61 6 making; promote consumer access to information relating to
61 7 medical care and gifts; reduce the inappropriate influence of
61 8 gifts and payments on provider medical decisions; limit annual
61 9 increases in the cost of health care; and assist the state in
61 10 its role as a purchaser of health care services and an
61 11 administrator of health care programs by enabling the state to
61 12 determine the effect of gifts on the cost, utilization, and
61 13 delivery of health care services.

61 14 Sec. 65. NEW SECTION. 155C.2 DEFINITIONS.

61 15 As used in this chapter, unless the context otherwise
61 16 requires:

61 17 1. "Biologic" means a biological product as defined in 42
61 18 U.S.C. } 262.

61 19 2. "Bona fide clinical trial" means any research project
61 20 that prospectively assigns human subjects to intervention and
61 21 comparison groups to study the cause and effect relationship
61 22 between a medical intervention and a health outcome.

61 23 3. "Department" means the department of administrative
61 24 services.

61 25 4. "Gift" means a payment, fee, food, entertainment,
61 26 travel, honorarium, subscription, advance, service, subsidy,
61 27 economic benefit, or anything of value provided, unless
61 28 consideration of equal or greater value is received, and
61 29 includes anything of value provided to a health care
61 30 practitioner for less than market value. "Gift" does not
61 31 include product samples or negotiated rebates or discounts.

61 32 5. "Health care practitioner" means a health care
61 33 professional who is licensed to prescribe prescription drugs,
61 34 or a partnership or corporation consisting of such health care
61 35 professionals, or an officer, employee, agent, or contractor
62 1 of such a health care professional acting in the course of
62 2 employment, agency, or contract related to or supportive of
62 3 the provision of health care by the health care professional.

62 4 6. "Manufacturer" means a person engaged in the
62 5 manufacturing, preparing, propagating, compounding,
62 6 processing, packaging, repackaging, distributing, or labeling
62 7 of prescription drugs, biologics, or medical devices.

62 8 7. "Medical device" means device as defined in section
62 9 155A.3.

62 10 8. "Prescription drug" means prescription drug as defined
62 11 in section 155A.3.

62 12 9. "Significant educational, scientific, or policy=making
62 13 conference or seminar" means an educational, scientific, or
62 14 policy=making conference or seminar that meets both of the
62 15 following requirements:

62 16 a. Is accredited by the accreditation council for
62 17 continuing medical education or a comparable organization.

62 18 b. Offers continuing medical education credit, features
62 19 multiple presenters on scientific research, or is authorized
62 20 by the sponsoring association to recommend or make policy.

62 21 10. "State health care program" means a program for which
62 22 the state purchases prescription drugs, biologics, or medical
62 23 devices, including but not limited to the medical assistance
62 24 program, or a state employee, corrections, or retirement
62 25 system program.

62 26 11. "Wholesaler" means wholesaler as defined in section
62 27 155A.3.

62 28 Sec. 66. NEW SECTION. 155C.3 GIFTS TO HEALTH CARE
62 29 PRACTITIONERS PROHIBITED.

62 30 1. A manufacturer or wholesaler, or a manufacturer's or
62 31 wholesaler's agent, who participates in a state health care
62 32 program shall not offer or give any gift to a health care
62 33 practitioner.

62 34 2. Notwithstanding subsection 1, the following gifts are
62 35 not prohibited but shall be disclosed pursuant to section
63 1 155C.4:

63 2 a. Payment to the sponsor of a significant educational,
63 3 scientific, or policy-making conference or seminar if the
63 4 payment is not made directly to a health care practitioner;
63 5 the payment is used solely for bona fide educational purposes;
63 6 and all conference or seminar activities are objective, free
63 7 from industry influence, and do not promote specific products.

63 8 b. Reasonable honoraria and payment of the reasonable
63 9 expenses of a health care practitioner who serves on the
63 10 faculty at a significant educational, scientific, or
63 11 policy-making conference or seminar pursuant to an explicit
63 12 contract with specific deliverables which are restricted to
63 13 scientific issues, not marketing efforts, and the content of
63 14 any presentation, including slides and written materials, are
63 15 determined by the health care practitioners.

63 16 c. Compensation for the substantial professional or
63 17 consulting services of a health care practitioner in
63 18 connection with a bona fide clinical trial pursuant to an
63 19 explicit contract with specific deliverables which are
63 20 restricted to scientific issues, not marketing efforts.

63 21 Sec. 67. NEW SECTION. 155C.4 DISCLOSURE OF EXEMPTED
63 22 GIFTS.

63 23 1. a. Annually, on or before December 1, every
63 24 manufacturer or wholesaler of prescription drugs, biologics,
63 25 or medical devices that participates in a state health care
63 26 program shall disclose to the department, the value, nature,
63 27 purpose, and recipient of any gift not prohibited in section
63 28 155C.3, which is provided by the manufacturer or wholesaler,
63 29 directly or through its agents, to any health care
63 30 practitioner or any other person in this state authorized to
63 31 prescribe, dispense, or purchase prescription drugs,
63 32 biologics, or medical devices in this state.

63 33 b. For each expenditure, the manufacturer or wholesaler
63 34 shall also identify the recipient and the recipient's address,
63 35 credentials, institutional affiliation, and state board or
64 1 drug enforcement agency numbers.

64 2 2. Each manufacturer or wholesaler subject to the
64 3 provisions of this section shall also disclose to the
64 4 department the name and address of the individual responsible
64 5 for the manufacturer's or wholesaler's compliance with this
64 6 section, or if this information has been previously reported,
64 7 any changes in the name or address of the individual
64 8 responsible for the manufacturer's or wholesaler's compliance
64 9 with this section.

64 10 3. The report shall be accompanied by payment of a fee, to
64 11 be established by rule of the department, to defray
64 12 administrative costs.

64 13 4. The department shall make all disclosed data publicly
64 14 available and easily searchable on its internet site.

64 15 Sec. 68. NEW SECTION. 155C.5 DEPARTMENTAL REPORTS.

64 16 The department shall provide an annual report to the
64 17 governor and the general assembly on or before January 15,
64 18 containing an analysis of the data submitted to the department
64 19 under section 155C.4. The report shall include all of the
64 20 following:

64 21 1. Information on gifts required to be disclosed under
64 22 section 155C.4, which shall be presented in aggregate form and
64 23 by selected types of health care practitioners or individual
64 24 health care practitioners, as prioritized each year by the
64 25 department and analyzed to determine whether prescribing
64 26 patterns by these health care practitioners reimbursed by the
64 27 state health care programs may reflect manufacturer's or
64 28 wholesaler's influence.

64 29 2. Information on violations and enforcement actions
64 30 brought pursuant to this chapter.

64 31 Sec. 69. NEW SECTION. 155C.6 PUBLIC RECORDS.

64 32 1. The information required to be submitted pursuant to
64 33 section 155C.4, and the data and reports compiled by the
64 34 department pursuant to section 155C.5, are public records.
64 35 2. Notwithstanding any other provision of law to the
65 1 contrary, the identity of health care practitioners and other
65 2 recipients of gifts, payments, and materials required to be
65 3 reported in this section do not constitute confidential
65 4 information or trade secrets.

65 5 Sec. 70. NEW SECTION. 155C.7 ENFORCEMENT == RULES.

65 6 1. The department may bring an action for injunctive
65 7 relief, costs, and attorneys fees, and to impose a civil
65 8 penalty of no more than ten thousand dollars per violation on
65 9 a manufacturer or wholesaler that fails to comply with any
65 10 provision of this chapter.
65 11 2. The department shall adopt rules as necessary to
65 12 administer this chapter.

65 13 Sec. 71. STUDY OF PROVISION OF PHARMACEUTICAL PRODUCT
65 14 SAMPLES == REPORT.

65 15 1. The department of public health shall convene an
65 16 advisory group of appropriate stakeholders to study the
65 17 advantages and disadvantages of the provision of
65 18 pharmaceutical product samples to the health care system and
65 19 to consumers in this state.
65 20 2. The advisory group shall review and analyze all of the
65 21 following:

65 22 a. The overall advantages and disadvantages of
65 23 pharmaceutical product samples.
65 24 b. The effect of the provision of pharmaceutical product
65 25 samples on the quality of health care received.
65 26 c. The influence of pharmaceutical product samples on
65 27 medication practices, prescribing behaviors, and requests for
65 28 changes in formularies.

65 29 d. The nature of the product and prescribing information
65 30 accompanying the pharmaceutical product samples, including
65 31 whether unbiased, evidence-based product and prescribing
65 32 information is made available.
65 33 e. The effectiveness and appropriateness of treatment as
65 34 influenced by the use of pharmaceutical product samples,
65 35 including whether the choice by the health care provider of an
66 1 available sample differs from what would have been the
66 2 provider's preferred choice.

66 3 f. The value of having pharmaceutical product samples
66 4 available based on the socioeconomic or insured status of
66 5 patients, and the economic consequences to the patient who
66 6 receives samples.

66 7 g. The increased short-term and long-term costs or savings
66 8 to the health care system through the availability of
66 9 pharmaceutical product samples, including the individual
66 10 short-term and long-term, out-of-pocket increases in cost or
66 11 savings to patients.

66 12 h. Regulatory, security, and safety issues related to the
66 13 use of pharmaceutical product samples, including the potential
66 14 for medication errors and interactions, the loss of pharmacist
66 15 interaction with patients regarding the pharmaceutical
66 16 product, and distribution practices.

66 17 i. The variation in use and advantages or disadvantages of
66 18 pharmaceutical product samples, based upon the type of health
66 19 care provider.

66 20 j. Alternatives to the current pharmaceutical product
66 21 sample practice, such as the use of vouchers for free sample
66 22 prescription drugs or the limitation of samples to only
66 23 generic or preferred brand name samples.

66 24 k. The views of various types of health care providers
66 25 regarding the use of pharmaceutical product samples.

66 26 3. The department shall submit a report of its findings
66 27 and recommendations to the governor and the general assembly
66 28 by December 15, 2009.

66 29 DATA MINING
66 30 Sec. 72. NEW SECTION. 155D.1 PURPOSES.

66 31 The purposes of this chapter are the following:

66 32 1. To safeguard the confidentiality of prescribing
66 33 information, protect the integrity of the doctor-patient
66 34 relationship, maintain the integrity and public trust in the
66 35 medical profession, combat vexatious and harassing sales
67 1 practices, restrain undue influence exerted by pharmaceutical
67 2 industry marketing representatives over prescribing decisions,
67 3 and further the state interest in improving the quality and
67 4 lowering the cost of health care.

67 5 2. To ensure the confidentiality of data held by a state
67 6 agency which could be used directly or indirectly to identify
67 7 a patient or a health care professional licensed to prescribe

67 8 drugs, biologics, or medical devices.

67 9 3. To ensure compliance with federal Medicaid law and
67 10 regulations prohibiting the disclosure and use of Medicaid
67 11 data except to administer the Medicaid program, and to ensure
67 12 that data held by the department of human services or its
67 13 agents that could directly or indirectly identify patients or
67 14 health care professionals licensed to prescribe products be
67 15 kept confidential.

67 16 4. To regulate the monitoring of prescribing practices
67 17 solely for commercial marketing purposes by entities selling
67 18 prescribed products, and not to regulate monitoring for other
67 19 uses, such as quality control, research unrelated to
67 20 marketing, or use by governments or other entities not in the
67 21 business of selling health care products.

67 22 Sec. 73. NEW SECTION. 155D.2 DEFINITIONS.

67 23 As used in this chapter, unless the context otherwise
67 24 requires:

67 25 1. "Biologic" means a biological product as defined in 42
67 26 U.S.C. } 262.

67 27 2. "Bona fide clinical trial" means a research project
67 28 that prospectively assigns human subjects to intervention and
67 29 comparison groups to study the cause and effect relationship
67 30 between a medical intervention and a health outcome.

67 31 3. "Individual identifying information" means information
67 32 which directly or indirectly identifies a prescriber or a
67 33 patient, and the information is derived from or relates to a
67 34 prescription for any prescribed product.

67 35 4. "Marketing" means an activity by a company or an agent
68 1 of the company making or selling prescribed products intended
68 2 to influence prescribing or purchasing choices of the
68 3 company's prescribed products, including but not limited to
68 4 any of the following:

68 5 a. Advertising, publicizing, promoting, or sharing
68 6 information about a prescribed product.

68 7 b. Identifying individuals to receive a message promoting
68 8 use of a particular prescribed product, including but not
68 9 limited to an advertisement, brochure, or contact by a sales
68 10 representative.

68 11 c. Planning the substance of a sales representative visit
68 12 or communication or the substance of an advertisement or other
68 13 promotional message or document.

68 14 d. Evaluating or compensating sales representatives.

68 15 e. Identifying individuals to receive any form of gift,
68 16 product sample, consultancy, or any other item, service,
68 17 compensation, or employment of value.

68 18 f. Advertising or promoting prescribed products directly
68 19 to patients.

68 20 5. "Medicaid program" means the medical assistance program
68 21 administered as specified under chapter 249A.

68 22 6. "Pharmacy" means pharmacy as defined in section 155A.3.

68 23 7. "Prescription drug" means prescription drug as defined
68 24 in section 155A.3.

68 25 8. "Prescribed product" means a biologic, prescription
68 26 drug, or a medical device.

68 27 9. "Prescriber" means a health care practitioner who is
68 28 licensed to prescribe prescription drugs, biologics, or
68 29 medical devices in this state.

68 30 10. "Regulated record" means information or documentation
68 31 from a prescription written by a prescriber doing business in
68 32 this state or a prescription dispensed in this state.

68 33 11. "State health care program" means a program for which
68 34 the state purchases prescribed products, including but not
68 35 limited to a state employee, corrections, or retirement system
69 1 program, but does not include the medical assistance program.

69 2 Sec. 74. NEW SECTION. 155D.3 PRIVACY PROVISIONS.

69 3 1. a. A person, including a state health care program,
69 4 shall not knowingly disclose or use regulated records that
69 5 include individual identifying information for the marketing
69 6 of a prescribed product.

69 7 b. The department of human services shall ensure that the
69 8 department, its employees, and agents, comply with the
69 9 limitations on redisclosure or use of medical assistance
69 10 program prescription information as provided for under state
69 11 and federal law and applicable federal regulations, and shall
69 12 have policies and procedures to ensure compliance with such
69 13 state and federal laws and federal regulations.

69 14 2. a. Regulated records containing individual identifying
69 15 information may be disclosed, sold, transferred, exchanged, or
69 16 used only for nonmarketing purposes including but not limited
69 17 to:

69 18 (1) Activities related to filling a valid prescription,

69 19 including but not limited to the dispensing of a prescribed
69 20 product to a patient or to the patient's authorized
69 21 representative; the transmission of regulated record
69 22 information between an authorized prescriber and a pharmacy;
69 23 the transfer of regulated record information between
69 24 pharmacies; the transfer of regulated records that may occur
69 25 if pharmacy ownership is changed or transferred and pharmacy
69 26 reimbursement.

69 27 (2) Law enforcement purposes as otherwise authorized or
69 28 required by statute or court order.

69 29 (3) Research including but not limited to bona fide
69 30 clinical trials, postmarketing surveillance research, product
69 31 safety studies, population-based public health research, and
69 32 research regarding the effects of health care practitioner
69 33 prescribing practices, and statistical reports if individual
69 34 identifying information is not published, redisclosed, or used
69 35 to identify or contact individuals.

70 1 (4) Product safety evaluations, product recalls and
70 2 specific risk management plans, as identified or requested by
70 3 the federal food and drug administration, or its successor
70 4 agency.

70 5 (5) Pharmacy reimbursement, formulary compliance, case
70 6 management related to the diagnosis, treatment, or management
70 7 of illness for a specific patient, including but not limited
70 8 to care management educational communications provided to a
70 9 patient about the patient's health condition, adherence to a
70 10 prescribed course of therapy, or other information about the
70 11 product being dispensed, treatment options, or clinical
70 12 trials.

70 13 (6) Utilization review by the state, by a health care
70 14 provider, or by the patient's insurance provider for health
70 15 care services, including but not limited to determining
70 16 compliance with the terms of coverage or medical necessity.

70 17 (7) The collection and analysis of product utilization
70 18 data for health care quality improvement purposes, including
70 19 but not limited to development of evidence-based treatment
70 20 guidelines or health care performance effectiveness and
70 21 efficiency measures, promoting compliance with evidence-based
70 22 treatment guidelines or health care performance measures, and
70 23 providing prescribers with information that details their
70 24 practices relative to their peers to encourage prescribing
70 25 consistent with evidence-based practice.

70 26 (8) The collection and dissemination of product
70 27 utilization data to promote transparency in evaluating
70 28 performance related to the health care quality improvement
70 29 measures.

70 30 (9) The transfer of product utilization data to and
70 31 through secure electronic health record or personal health
70 32 record systems.

70 33 (10) Use by any government agency or government agency
70 34 sponsored program in carrying out its functions, or by any
70 35 private person acting on behalf of a federal, state, or local
71 1 agency in carrying out its functions.

71 2 (11) Use in connection with any civil, criminal,
71 3 administrative, or arbitral proceeding in any federal, state,
71 4 or local court or agency or before any self-regulatory body,
71 5 including but not limited to the service of process,
71 6 investigation in anticipation of litigation, and the execution
71 7 or enforcement of judgments and orders, or pursuant to an
71 8 order of a federal, state, or local court.

71 9 b. An authorized recipient of regulated records containing
71 10 individual identifying information may resell, reuse, or
71 11 redisclose the information only as permitted under paragraph
71 12 "a".

71 13 c. An authorized recipient that resells, reuses, or
71 14 rediscloses individual identifying information covered by this
71 15 chapter shall maintain for a period of five years, records
71 16 identifying each person or entity that receives the
71 17 information and the permitted purpose for which the
71 18 information will be used. The authorized recipient shall make
71 19 such records available to any person upon request.

71 20 3. This section shall not be interpreted to prohibit
71 21 conduct involving the collection, use, transfer, or sale of
71 22 regulated records for marketing purposes if all of the
71 23 following conditions apply:

71 24 a. The data is aggregated.

71 25 b. The data does not contain individually identifying
71 26 information.

71 27 c. There is no reasonable basis to believe that the data
71 28 can be used to obtain individually identifying information.

71 29 4. This section shall not prevent any person from

71 30 disclosing individual identifying information to the
71 31 identified individual if the information does not include
71 32 protected information pertaining to any other person.
71 33 Sec. 75. NEW SECTION. 155D.4 CIVIL PENALTY ==
71 34 ENFORCEMENT == RULEMAKING.
71 35 1. Any person who knowingly fails to comply with the
72 1 requirements of this chapter or rules adopted pursuant to this
72 2 chapter by using or disclosing regulated records in a manner
72 3 not authorized by this chapter or rules adopted pursuant to
72 4 this chapter is subject to a civil penalty of not more than
72 5 fifty thousand dollars per violation. Each disclosure of a
72 6 regulated record constitutes a separate violation.
72 7 2. The attorney general shall enforce payment of penalties
72 8 assessed under this section.
72 9 3. The board of pharmacy shall adopt rules to administer
72 10 this chapter including the assessment of penalties under this
72 11 section.

72 12 Sec. 76. NEW SECTION. 155D.5 CONSUMER FRAUD.
72 13 A violation of this chapter is an unfair or deceptive act
72 14 in trade or commerce and an unfair method of competition under
72 15 the consumer fraud Act, section 714.16.

72 16 DIVISION VII
72 17 HEALTH CARE TRANSPARENCY

72 18 Sec. 77. Section 135.11, Code 2009, is amended by adding
72 19 the following new subsection:
72 20 NEW SUBSECTION. 32. Establish an office of health care
72 21 reform to coordinate health care reform initiatives and
72 22 activities related to the medical home system advisory
72 23 council, the electronic health information advisory council
72 24 and executive committee, the prevention and chronic care
72 25 management advisory council, the direct care worker task
72 26 force, the health and long-term care access technical advisory
72 27 committee, the clinicians advisory panel, the long-term living
72 28 initiatives of the department of elder affairs, medical
72 29 assistance and hawk=i program expansions and initiatives,
72 30 prevention and wellness initiatives including but not limited
72 31 to those administered through the Iowa healthy communities
72 32 initiative pursuant to section 135.27 and through the
72 33 governor's council on physical fitness and nutrition, health
72 34 care transparency activities, and other health care
72 35 reform-related advisory bodies and activities to provide
73 1 direction and promote collaborative efforts among health care
73 2 providers involved in the initiatives and activities. The
73 3 office shall also monitor state and federal health care reform
73 4 initiatives to promote further coordination and collaboration
73 5 of health care reform initiatives and activities.

73 6 Sec. 78. Section 135.156, subsection 3, paragraph c,
73 7 subparagraph (2), Code 2009, is amended to read as follows:
73 8 (2) Consult with the Iowa communications network, private
73 9 fiberoptic networks, and any other communications entity to
73 10 seek collaboration, avoid duplication, and leverage
73 11 opportunities in developing a network backbone. Any public or
73 12 private network developed shall comply with the single patient
73 13 identifier, standard continuity of care record, and other
73 14 requirements developed by the executive committee. All
73 15 portions of the public or private network backbone shall be
73 16 structured in a manner which allows for seamless
73 17 interoperability between such portions of the network.

73 18 Sec. 79. Section 135.165, Code 2009, is amended to read as
73 19 follows:

73 20 135.165 HEALTH CARE TRANSPARENCY == REPORTING REQUIREMENTS
73 21 == HOSPITALS AND NURSING FACILITIES.

73 22 1. Each hospital and nursing facility in this state that
73 23 is recognized by the Internal Revenue Code as a nonprofit
73 24 organization or entity shall submit to the department of
73 25 public health and the legislative services agency, annually, a
73 26 copy of the hospital's or nursing facility's internal revenue
73 27 service form 990, including but not limited to schedule J or
73 28 any successor schedule that provides compensation information
73 29 for certain officers, directors, trustees, and key employees,
73 30 information about the highest compensated employees, and
73 31 information regarding revenues, expenses, excess or surplus
73 32 revenues, and reserves within ninety days following the due
73 33 date for filing the hospital's or nursing facility's return
73 34 for the taxable year.

73 35 2. Each hospital and nursing facility in this state that
74 1 is not recognized by the Internal Revenue Code as a nonprofit
74 2 organization or entity shall submit to the department of
74 3 public health and the legislative services agency, annually,
74 4 in a format specified by rule of the department, the
74 5 information required to be submitted by nonprofit hospitals

74 6 and nursing facilities pursuant to subsection 1.

74 7 Sec. 80. NEW SECTION. 135.166 HEALTH CARE DATA ==
74 8 COLLECTION FROM HOSPITALS.

74 9 1. The department of public health shall enter into a
74 10 memorandum of understanding to utilize the Iowa hospital
74 11 association to act as the department's intermediary in
74 12 collecting, maintaining, and disseminating hospital inpatient,
74 13 outpatient, and ambulatory information, as initially
74 14 authorized in 1996 Iowa Acts, chapter 1212, section 5,
74 15 subsection 1, paragraph "a", subparagraph (4) and 641 IAC
74 16 177.3.

74 17 2. The memorandum of understanding shall include but is
74 18 not limited to provisions that address the duties of the
74 19 department and the Iowa hospital association; the collection,
74 20 reporting, use and disclosure, storage, confidentiality,
74 21 publication, and ownership of the data; access by the
74 22 department of any database of the data maintained by the Iowa
74 23 hospital association; any fees for the collection,
74 24 maintenance, or distribution of the data; and the bases for
74 25 amendment or termination of the memorandum of understanding.

74 26 Sec. 81. HEALTH CARE QUALITY AND COST TRANSPARENCY ==
74 27 WORKGROUP.

74 28 1. a. A health care quality and cost transparency
74 29 workgroup is created to develop recommendations for
74 30 legislation and policies regarding health care quality and
74 31 cost including measures to be utilized in providing
74 32 transparency to consumers of health care and health care
74 33 coverage.

74 34 b. Membership of the workgroup shall include but is not
74 35 limited to representatives of the Iowa healthcare
75 1 collaborative, the department of public health, the department
75 2 of human services, the insurance division of the department of
75 3 commerce, the Iowa hospital association, the Iowa medical
75 4 society, the Iowa health buyers alliance, the AARP Iowa
75 5 chapter, the university of Iowa public policy center, and
75 6 other interested consumers, advocates, purchasers, providers,
75 7 and legislators.

75 8 c. The department of public health shall provide staffing
75 9 assistance to the workgroup.

75 10 2. The workgroup shall do all of the following:

75 11 a. Review the approaches of other states in addressing
75 12 health care transparency information.

75 13 b. Develop and compile recommendations and strategies to
75 14 lower health care costs and health care coverage costs for
75 15 consumers and businesses.

75 16 c. Review and recommend health care quality and cost
75 17 measures to be reported by health plans, hospitals, and
75 18 physicians. Any measure recommended shall be evidence-based
75 19 and clinically important, reasonably feasible to implement,
75 20 and easily understood by the health care consumer.

75 21 d. Develop a plan for the collection, analysis, and
75 22 publishing of clinical data from physicians and health care
75 23 providers other than hospitals.

75 24 e. Develop a plan to collect and publish as a database,
75 25 consumer health care quality and cost information designed to
75 26 make available to consumers transparent health care cost
75 27 information, quality information including but not limited to
75 28 hospital infection rates, medication and surgical errors, and
75 29 such other information necessary to empower consumers,
75 30 including uninsured consumers, to make economically sound and
75 31 medically appropriate health care decisions.

75 32 3. The workgroup shall submit a written report of the
75 33 workgroup's findings, recommendations, and plans, to the
75 34 general assembly on or before December 15, 2009.

75 35 EXPLANATION

76 1 This bill relates to health care, health care providers,
76 2 and health care coverage, and provides penalties.

76 3 DIVISION I. IOWA CHOICE INSURANCE EXCHANGE. Division I of
76 4 the bill contains new Code chapter 514M. The purpose of the
76 5 chapter is to ensure that all children and all other Iowans in
76 6 the state have affordable, quality health care coverage, and
76 7 to decrease health care costs and health care coverage costs.

76 8 The bill creates the Iowa choice insurance exchange as a
76 9 nonprofit corporation under the aegis of the insurance
76 10 division of the department of commerce. All health and
76 11 accident insurance carriers, all organized delivery systems
76 12 licensed by the department of public health to provide health
76 13 insurance or health care services in Iowa, and all other
76 14 insurers designated by the exchange are members of the
76 15 exchange.

76 16 The exchange is required to exercise its powers through a

76 17 board of directors. The board of directors consists of 11
76 18 voting members representative of specified constituencies
76 19 appointed by the governor and subject to confirmation by the
76 20 senate, and eight nonvoting members including four members of
76 21 the general assembly. The voting members of the board are
76 22 required to appoint an executive director of the exchange.
76 23 The exchange is considered a governmental body for the
76 24 purposes of the state open meetings law and a government body
76 25 for the purposes of the state open records law.

76 26 The exchange is required to submit a plan of operation to
76 27 the commissioner of insurance for approval. At the end of
76 28 each year the exchange is required to determine its net
76 29 premiums and payments received, the expenses of
76 30 administration, and incurred losses and to recover any losses
76 31 by assessing all members of the exchange as specified in the
76 32 bill. The exchange is required to conduct annual audits and
76 33 issue yearly financial reports to the commissioner of
76 34 insurance, the governor, the speaker of the house of
76 35 representatives, the majority leader of the senate, and the

77 1 legislative fiscal committee.

77 2 The exchange is charged with developing a comprehensive
77 3 health care coverage plan to accomplish the purposes of the
77 4 new Code chapter including access to public or private health
77 5 care coverage for all Iowans, especially children, which may
77 6 be subsidized or unsubsidized, depending on family income.

77 7 The exchange is also required to design and implement a
77 8 health care coverage program called Iowa choice, which offers
77 9 private health care coverage that meets certain minimum
77 10 standards of quality and affordability with options to
77 11 purchase at least three levels of benefits, and to design and
77 12 administer a subsidy program for payment of premiums for
77 13 health care coverage for low-income people that complements
77 14 Medicaid and includes cost-sharing by the insured using a
77 15 sliding scale based on income utilizing the federal poverty
77 16 level guidelines. Subsidies may be provided to children,
77 17 adults, and families with incomes up to 400 percent of the
77 18 federal poverty level guidelines. The comprehensive plan
77 19 shall consider offering state health insurance coverage to
77 20 nonstate public employees and employees of nonprofit employers
77 21 and small employers. The exchange shall also study the cost
77 22 to the state of providing public health care to undocumented
77 23 children and study the use of pharmacy benefit managers in the
77 24 state.

77 25 The Iowa choice insurance exchange fund is created in the
77 26 state treasury as a separate fund under the control of the
77 27 exchange to be credited with all moneys collected from
77 28 premiums paid for health care plans offered by the exchange,
77 29 and any other funds that are appropriated or transferred to
77 30 the fund. These funds shall only be appropriated to the
77 31 exchange to accomplish the purposes set forth in new Code
77 32 chapter 514M.

77 33 The board of the exchange is also required to design and
77 34 implement a program to protect the health of all Iowans, that
77 35 includes a timetable and procedures for implementation, to
78 1 ensure that all children and adults in the state have health
78 2 care coverage, to assign and enroll children without such
78 3 coverage to appropriate coverage, and to collaborate with the
78 4 department of human services, the insurance division of the
78 5 department of commerce, and with members of the exchange to
78 6 institute health insurance reforms.

78 7 COORDINATING AMENDMENTS. Coordinating amendments are made
78 8 in Code section 21.2(1) indicating that the exchange is
78 9 subject to the state open meetings law and to Code section
78 10 22.1(1) making the exchange subject to the state open records
78 11 law. Coordinating amendments are also made in Code chapter
78 12 514E by removing duties and powers from the Iowa comprehensive
78 13 health insurance association which are assigned under the bill
78 14 to the Iowa choice insurance exchange and repealing a
78 15 provision creating the Iowa choice health care coverage
78 16 advisory council.

78 17 DIVISION II. HEALTH CARE COVERAGE OF ADULT CHILDREN. Code
78 18 section 422.7 is amended to provide that if the health
78 19 benefits coverage or insurance of an Iowa taxpayer includes
78 20 coverage of a nonqualified tax dependent as determined by the
78 21 federal internal revenue service, the amount of the value of
78 22 that coverage is not subject to state income tax. This
78 23 amendment applies retroactively to January 1, 2009.

78 24 Code section 509.3(8), relating to group health insurance,
78 25 Code section 509A.13B, relating to group health insurance for
78 26 public employees, and Code section 514A.3B(2), relating to
78 27 individual policies of health insurance, are amended to

78 28 require that adult children who are unmarried, residents of
78 29 this state and up to 25 years of age, or who are full-time
78 30 students, be allowed to reenroll in previously existing
78 31 dependent coverage of their parents. Currently, those
78 32 provisions only allow continuation of such existing coverage.
78 33 DIVISION III. MEDICAL ASSISTANCE AND HAWK=I PROVISIONS.
78 34 Division III of this bill includes provisions relating to the
78 35 medical assistance (Medicaid) and hawk=i programs.

79 1 The division directs the department of human services (DHS)
79 2 to provide state-only funded medical assistance or hawk=i
79 3 coverage, as appropriate, to individuals under 19 years of age
79 4 who meet income eligibility requirements under the respective
79 5 program and for whom federal financial participation is or
79 6 becomes available.

79 7 The division amends the income tax provision for reporting
79 8 of a dependent child's health care coverage status to require,
79 9 beginning with the tax returns for tax year 2010, that a
79 10 person who files an individual or joint income tax return
79 11 indicate the presence or absence of health care coverage for
79 12 each dependent child for whom an exemption is claimed. If the
79 13 taxpayer indicates that a dependent child does not have health
79 14 care coverage and the income of the taxpayer's tax return does
79 15 not exceed the highest level of income eligibility standard
79 16 for the Medicaid or hawk=i program, the department of revenue
79 17 is required to send a notice to the taxpayer that the
79 18 dependent child may be eligible for these programs and to
79 19 provide information to the taxpayer about how to enroll the
79 20 dependent child in the appropriate program. The taxpayer is
79 21 then required to submit an application for the appropriate
79 22 program within 90 days of receiving the enrollment
79 23 information. The department of revenue, in cooperation with
79 24 DHS, is directed to adopt rules including rules regarding the
79 25 enforcement of the required provision of information and
79 26 required application for an appropriate program. Information
79 27 to be reported by the department of revenue includes whether a
79 28 taxpayer who claims a dependent indicates coverage or lack of
79 29 coverage for the dependent, and the number of those indicating
79 30 the absence of coverage who comply or do not comply with the
79 31 requirement for application for an appropriate program, and
79 32 any enforcement action taken. This provision takes effect
79 33 July 1, 2010.

79 34 The division provides for coverage under the Medicaid
79 35 program of a pregnant woman with a family income of up to 300
80 1 percent of the federal poverty level, beginning July 1, 2009.

80 2 The division includes provisions to improve access to and
80 3 retention in the Medicaid and hawk=i programs. The division
80 4 directs DHS to implement a number of provisions included in
80 5 the federal Children's Health Insurance Program
80 6 Reauthorization Act of 2009 under both the Medicaid and hawk=i
80 7 programs including implementing the premium assistance
80 8 options; including translation and interpreter services as a
80 9 covered benefit; utilizing a joint application and
80 10 supplemental forms, and the same application and renewal
80 11 verification processes for the medical assistance and hawk=i
80 12 programs; implementing administrative or paperless
80 13 verification at renewal; utilizing presumptive eligibility;
80 14 and utilizing the express lane option to reach and enroll
80 15 children in the programs. The bill also directs DHS to allow
80 16 for the submission of one pay stub per employer by an
80 17 individual as verification of earned income when it is
80 18 indicative of future income and to allow for the averaging of
80 19 three years of income for self-employed families to establish
80 20 eligibility under the Medicaid and hawk=i programs, and
80 21 directs DHS to extend the period for annual renewal by medical
80 22 assistance members by mailing the renewal form to the member
80 23 on the first day of the month prior to the month of renewal.
80 24 The division also allows the hawk=i program to provide the
80 25 supplemental dental-only coverage to children who have private
80 26 coverage but would otherwise be eligible for the hawk=i
80 27 program, which is a provision allowed under the federal
80 28 Children's Health Insurance Program Reauthorization Act of
80 29 2009.

80 30 The division also eliminates the hawk=i expansion program,
80 31 which was to extend coverage to children up to 300 percent of
80 32 the federal poverty level through state-only funding, and
80 33 folds the hawk=i expansion population into the existing hawk=i
80 34 program which population is eligible for federal matching
80 35 funds pursuant to the federal Children's Health Insurance
81 1 Program Reauthorization Act of 2009. The division makes other
81 2 conforming changes relative to eliminating the separate hawk=i
81 3 expansion program. The division provides that Medicaid and

81 4 hawk=i coverage are creditable coverage, a qualifying event,
81 5 and qualifying existing coverage for the purposes of
81 6 portability to private and individual or group health
81 7 insurance coverage. The division also directs DHS and the
81 8 department of public health in cooperation with other
81 9 appropriate agencies to apply for federal grants to promote
81 10 outreach activities and quality child health outcomes under
81 11 the Medicaid and hawk=i programs as provided under the federal
81 12 Children's Health Insurance Program Reauthorization Act of
81 13 2009.

81 14 DIVISION IV. VOLUNTEER HEALTH CARE PROVIDERS. Division IV
81 15 of the bill expands the volunteer health care provider program
81 16 to include health care provider offices. The division
81 17 provides that a health care provider office providing free
81 18 care under the program is considered a state agency for the
81 19 sole purpose of the program and for Code chapter 669 (State
81 20 Tort Claims Act) and is to be afforded protection under Code
81 21 chapter 669 for all claims arising from the provision of free
81 22 care by a health care provider registered with the program and
81 23 complying with the requirements of the program. Additionally,
81 24 a health care provider providing free care under the program
81 25 at a health care provider office is considered an employee of
81 26 the state under Code chapter 669 and is afforded protection as
81 27 an employee of the state if the health care provider is
81 28 registered with the department of public health and provides
81 29 care at the health care provider office. The division defines
81 30 "health care provider office" as the private office or clinic
81 31 of an individual health care provider or group of health care
81 32 providers but does not include a field dental clinic, a free
81 33 clinic, or a hospital.

81 34 DIVISION V. HEALTH CARE WORKFORCE SUPPORT INITIATIVE.
81 35 Division V of the bill establishes a health care workforce
82 1 support initiative, including a health care workforce shortage
82 2 fund.

82 3 The division creates a health care workforce shortage fund
82 4 and creates accounts within the fund under the control of the
82 5 college student aid commission, the department of public
82 6 health, the governing group of the Iowa health care
82 7 collaborative safety net provider network, or the state entity
82 8 identified for receipt of federal funds by the federal
82 9 government for a specified health care workforce shortage
82 10 initiative. The fund and the accounts in the fund consist of
82 11 moneys appropriated from the general fund of the state; moneys
82 12 received from the federal government; contributions, grants,
82 13 and other moneys from communities and health care employers;
82 14 and moneys from any other public or private source. The
82 15 entities with control of the moneys are authorized to accept
82 16 contributions, grants, and in-kind contributions, to support
82 17 the purposes of the fund and the accounts. The fund consists
82 18 of the medical residency training account under the control of
82 19 the department of public health; the health care professional
82 20 and nurse workforce shortage initiative account under the
82 21 control of the college student aid commission; the safety net
82 22 provider network workforce shortage account under the control
82 23 of the governing group of the Iowa collaborative safety net
82 24 provider network; and the health care workforce shortage
82 25 national initiatives account under the control of the state
82 26 entity identified by the federal government providing the
82 27 funds. The bill specifies the purposes for which the moneys
82 28 in the fund and the accounts can be used and identifies
82 29 existing state programs or entities that may receive moneys in
82 30 order to draw down the maximum amount of federal funding for
82 31 health care workforce shortage programs and initiatives. The
82 32 bill provides that state appropriations from the fund shall be
82 33 made in equal amounts to the accounts and that any federal
82 34 funding received, unless otherwise provided by the source of
82 35 the funds, is to be allocated equally between the workforce
83 1 represented by the Iowa collaborative safety net provider
83 2 network and other eligible health care providers. The
83 3 division limits administrative costs to 5 percent of the
83 4 moneys in each account.

83 5 The division directs the department of public health to
83 6 establish a medical residency training state matching grants
83 7 program to provide grants to sponsors of accredited graduate
83 8 medical education residency programs in the state to
83 9 establish, expand, or support medical residency training
83 10 programs. The grant funds may be used to support medical
83 11 residency programs through the establishment of new or
83 12 alternative campus accredited medical residency training
83 13 programs, new residency positions within existing accredited
83 14 medical residency or fellowship training programs, or

83 15 residency positions which are in excess of the federal
83 16 Medicare residency cap. The department is to adopt rules
83 17 relating to eligibility requirements, an application process,
83 18 criteria for preference in the awarding of grants, criteria
83 19 for determining the amount of a grant, and use of the funds
83 20 awarded.

83 21 The division directs the college student aid commission to
83 22 establish a health care professional incentive payment program
83 23 to assist in the recruitment and retaining of health care
83 24 professionals. The commission is to administer the program
83 25 with the assistance of Des Moines university==osteopathic
83 26 medical center (DMU), and DMU is to receive a fee for
83 27 administration of the program. The commission, with the
83 28 assistance of DMU, is directed to adopt rules pursuant to Code
83 29 chapter 17A relating to the establishment and administration
83 30 of the program, including rules addressing eligibility and
83 31 qualification requirements for health care professionals,
83 32 communities, and health care employers participating in the
83 33 program, the process for awarding incentive payments, public
83 34 awareness and dissemination of applications, the amount of the
83 35 incentive payment and the specifics of obligated service for a
84 1 recipient, determination of the conditions of incentive
84 2 payment applicable to an applicant, enforcement of the state's
84 3 rights under or incentive payment agreement, a process for
84 4 monitoring compliance with eligibility requirements, obligated
84 5 service provisions, and use of funds by the program and
84 6 program recipients. The division also provides that a
84 7 recipient is responsible for reporting on federal income tax
84 8 forms any amount received through the program, to the extent
84 9 required by federal law. However, a recipient in compliance
84 10 with the requirements of the program is not subject to state
84 11 income taxation for incentive payments received through the
84 12 program.

84 13 The division includes community colleges in the existing
84 14 nurse and nurse education loan forgiveness program and also
84 15 directs the commission to establish two programs under a
84 16 nursing workforce shortage initiative. The nurse educator
84 17 incentive payment program is established to recruit and retain
84 18 nurse educators. The program provides for an incentive
84 19 payment of up to \$20,000 for a nurse educator who remains
84 20 teaching in a qualifying position for a period of not less
84 21 than four consecutive academic years. The nurse educator and
84 22 the commission are required to enter into an agreement
84 23 specifying the obligations of the nurse educator and the
84 24 commission. If the nurse educator leaves the teaching
84 25 position prior to teaching for four consecutive academic
84 26 years, the nurse educator is liable to repay the amount of the
84 27 incentive payment paid through the program plus interest.
84 28 However, if the nurse educator leaves the teaching position
84 29 involuntarily, the nurse educator is liable to repay only the
84 30 pro rata portion of the amount based on incompleting years of
84 31 service. The division directs the commission to adopt rules
84 32 for the program including specifying what constitutes a
84 33 qualifying teaching position.

84 34 The commission is also required to establish a nursing
84 35 faculty fellowship program to provide funds to nursing schools
85 1 in the state for fellowships for individuals employed in
85 2 qualifying positions on the nursing faculty. The program is
85 3 designed to assist nursing schools in filling vacancies in
85 4 qualifying positions throughout the state. The commission, in
85 5 consultation with the department of public health and in
85 6 cooperation with nursing schools throughout the state, is to
85 7 develop a distribution formula which provides that no more
85 8 than 30 percent of the available funds are awarded to a single
85 9 nursing school. Additionally, the program limits funding for
85 10 a qualifying position in a nursing school to no more than
85 11 \$10,000 per year for up to three years. The commission, in
85 12 consultation with the department of public health, is required
85 13 to adopt rules for administration of the program including
85 14 determining what constitutes a qualifying position at a
85 15 nursing school. In determining eligibility for a fellowship,
85 16 the commission is to consider the length of time a qualifying
85 17 position has gone unfilled at a nursing school, documented
85 18 recruiting efforts by a nursing school, the geographic
85 19 location of a nursing school, the type of nursing program
85 20 offered at the nursing school, and the need for the specific
85 21 nursing program in the state.

85 22 The division directs the Iowa collaborative safety net
85 23 provider network governing group to establish a safety net
85 24 provider incentive payment program to administer recruitment
85 25 and retention initiatives that may include but are not limited

85 26 to loan repayment and loan forgiveness programs, and programs
85 27 to address safety net provider shortages. The bill directs
85 28 the department of public health in cooperation with the
85 29 collaborative to adopt rules to implement and administer the
85 30 initiatives.

85 31 The division requires the commission to submit an annual
85 32 report to the governor and the general assembly regarding the
85 33 status of the health care workforce support initiative,
85 34 including the balance remaining in and appropriations from the
85 35 workforce shortage fund.

86 1 The division repeals sections relating to the osteopathic
86 2 physician recruitment program, which is replaced with the
86 3 health care professional incentive payment program established
86 4 in the division.

86 5 The division also directs the Code editor to create a new
86 6 division in Code chapter 261 (college student aid commission),
86 7 the health care workforce support initiative.

86 8 DIVISION VI. PHARMACEUTICAL-RELATED PROVISIONS. Division
86 9 VI of the bill includes various pharmaceutical-related
86 10 provisions.

86 11 The division includes provisions relating to medication
86 12 therapy management. The division provides findings of the
86 13 general assembly related to the utilization and reimbursement
86 14 of pharmaceutical case management services under the Medicaid
86 15 program to direct that all health insurance plans in the state
86 16 examine the feasibility and efficacy of including medication
86 17 therapy management as a covered benefit under individual and
86 18 group health insurance policies. If an insurance plan
86 19 determines that inclusion is feasible and efficacious, the
86 20 general assembly encourages the plan to provide such coverage
86 21 by January 1, 2010. If the plan determines the opposite, the
86 22 plan is to submit to the chairpersons of the general
86 23 assembly's committees on human resources a written report
86 24 detailing the plan's examination and analysis of the issue and
86 25 any reasons and supporting data for not including medication
86 26 therapy management as a covered benefit. Under the division,
86 27 "medication therapy management" means the same as
86 28 pharmaceutical case management services under the Medicaid
86 29 program.

86 30 The division directs the board of pharmacy to establish and
86 31 administer an evidence-based prescription drug education
86 32 program designed to provide health care professionals who are
86 33 licensed to prescribe or dispense prescription drugs with
86 34 information and education regarding the therapeutic and
86 35 cost-effective utilization of prescription drugs. The
87 1 division specifies the entities with which the board is to
87 2 collaborate in establishing and administering the program
87 3 including physicians, pharmacists, private insurers,
87 4 hospitals, pharmacy benefits managers, the medical assistance
87 5 drug utilization review commission, medical and pharmacy
87 6 schools, and other entities providing evidence-based education
87 7 to health care professionals that are licensed to prescribe or
87 8 dispense prescription drugs. The division authorizes the
87 9 board to contract with an Iowa-based college of pharmacy to
87 10 provide technical and clinical support to the program, and
87 11 provides that the department of public health may establish
87 12 and collect fees from private payors for participation in the
87 13 program, and seek funding from nongovernmental health
87 14 foundations or other nonprofit charitable foundations to
87 15 establish and administer the program.

87 16 The division prohibits gifts to health care practitioners
87 17 from manufacturers and wholesalers of prescription drugs,
87 18 biologics, and medical devices, who participate in state
87 19 health programs, with limited exceptions. For the purposes of
87 20 the division, "gifts" does not include product samples or
87 21 negotiated rebates or discounts. The division also requires
87 22 the disclosure of information about gifts excluded from the
87 23 ban, and requires the compilation of annual reports analyzing
87 24 this data by the department of administrative services. The
87 25 division provides for injunctive relief and civil penalties
87 26 for violations related to the gift prohibition. The division
87 27 also provides for the convening of an advisory group by the
87 28 department of public health to study the advantages and
87 29 disadvantages of the provision of pharmaceutical product
87 30 samples. The department is required to submit a report of its
87 31 findings to the governor and the general assembly by December
87 32 15, 2009.

87 33 The division includes provisions relating to the
87 34 safeguarding of the confidentiality of prescribing information
87 35 (data mining). The division establishes purposes of the new
88 1 Code chapter (155D), including that it is the chapter's

88 2 purpose to regulate the monitoring of prescribing practices
88 3 solely for commercial marketing purposes by entities selling
88 4 prescribed products, and not to regulate monitoring for other
88 5 uses, such as quality control, research unrelated to
88 6 marketing, or use by governments or other entities not in the
88 7 business of selling health care products.

88 8 The division provides privacy protections including that a
88 9 person, including a state health care program, shall not
88 10 knowingly disclose or use regulated records that include
88 11 individual identifying information to market a prescribed
88 12 product. The division also directs DHS as the Medicaid agency
88 13 to ensure that DHS, its employees, and agents, comply with the
88 14 limitations on redisclosure or use of medical assistance
88 15 program prescription information as provided for under state
88 16 and federal law and applicable federal regulations.

88 17 The division provides that regulated records containing
88 18 individual identifying information may be disclosed, sold,
88 19 transferred, exchanged, or used only for nonmarketing purposes
88 20 and specifies some of these nonmarketing purposes.

88 21 The division provides that it is not to be interpreted to
88 22 prohibit conduct involving the collection, use, transfer, or
88 23 sale of regulated records for marketing purposes if the data
88 24 is aggregated, the data does not contain individually
88 25 identifying information, and there is no reasonable basis to
88 26 believe that the data can be used to obtain individually
88 27 identifying information. The division does not prevent any
88 28 person from disclosing individual identifying information to
88 29 the identified individual if the information does not include
88 30 protected information pertaining to any other person.

88 31 The division provides that a person who knowingly fails to
88 32 comply with the requirements of the division or rules adopted
88 33 pursuant to the division by using or disclosing regulated
88 34 records in a manner not authorized by the division or rules
88 35 adopted under the division is subject to a civil penalty of
89 1 not more than \$50,000 per violation. The division directs the
89 2 attorney general to enforce payment of penalties assessed
89 3 under the division and directs the board of pharmacy to adopt
89 4 rules to administer the division including the assessing of
89 5 penalties.

89 6 A violation of the new Code chapter may be enforced through
89 7 Iowa's consumer fraud Act.

89 8 DIVISION VII. HEALTH CARE TRANSPARENCY. Division VII of
89 9 the bill relates to health care transparency. The division
89 10 directs the director of public health to establish an office
89 11 of health care reform to coordinate health care reform
89 12 initiatives and activities of various health care
89 13 reform-related advisory bodies and activities in the state as
89 14 well as to monitor state and federal health care reform
89 15 initiatives and activities.

89 16 The division provides with regard to electronic health
89 17 records that any public or private network developed shall
89 18 comply with the requirements developed by the electronic
89 19 health information executive committee, and that all portions
89 20 of the public or private network backbone shall be structured
89 21 in a manner which allows for seamless interoperability between
89 22 the portions of the network.

89 23 The division requires each hospital and nursing facility in
89 24 the state that is not a nonprofit entity, to annually submit
89 25 to the department of public health and the legislative
89 26 services agency information to be submitted by nonprofit
89 27 hospitals or nursing facilities relating to the internal
89 28 revenue services form 990.

89 29 The division directs the department of public health to
89 30 enter into a memorandum of understanding to utilize the Iowa
89 31 hospital association to act as the department's intermediary
89 32 in collecting, maintaining, and disseminating hospital
89 33 inpatient, outpatient, and ambulatory information.

89 34 The division creates a health care quality and cost
89 35 transparency workgroup to develop recommendations for
90 1 legislation and policies regarding health care quality and
90 2 cost. The division specifies the membership of the workgroup
90 3 and instructs the department of public health to provide
90 4 staffing assistance to the workgroup. The division specifies
90 5 the duties of the workgroup and directs the workgroup to
90 6 submit a written report of its findings, recommendations, and
90 7 plans to the general assembly on or before December 15, 2009.

90 8 LSB 1747SV 83

90 9 pf/rj/14